THE GRIEF RESPONSES OF MIDDLE-AGED SPOUSES: SUICIDE AND NON-SUICIDE COMPARED

A Dissertation

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by

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This dissertation, written by

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under the direction of his *Faculty Committee, and approved by its members, has been presented to and accepted by the Faculty of the School of Theology at Claremont in partial fulfillment of the requirements for the degree of*

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To my wife

Karen

The Quiet Despair of Grief

It was like walking down a hallway with about forty doors, and never being able to find a door that's open. It was just a quiet, black, sick feeling. And you wanted to find a door that's open, or some outlet, or some escape, and no matter what you did the door wouldn't open. I mean you'd get out with friends or whatever, but it lives with you.

--From the author's interview with one of the subjects of this study.

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CHAPTER I

INTRODUCTION

I. PURPOSE OF THE DISSERTATION AND THE PROBLEM BEING STUDIED

The problem of suicide and the difficulty in dealing with it is becoming increasingly evident to ministers, mental health professionals, and the general populace. The uneasiness that many feel in attempting to help the bereaved is also well known. The purpose of the research which was done for this dissertation was to combine the concerns of these two areas (suicide and grief), and to study how the surviving spouse of a suicide, in comparison to the surviving spouse of a non-suicidal death, reacts to the loss of his or her marriage partner.

In February, 1970, the National Institute of Mental Health held a conference in Phoenix on "Suicide in the Seventies," which focused on what people in suicidology should be doing in the new decade. Three of the six position papers presented at this conference indicated a need for a greater knowledge concerning families of completed suicides, the grief of suicide survivors, and how to effectively help these families. The paper by Maris, Stone, and others, indicated the need for studying and reconstructing the

life histories and situational components of completed suicides.[1] Farberow, in his paper on research in suicide, stated, ". . . clergymen could use such information [about death and grief] in working with families where suicide, death or suicidal behavior has occurred."[2] McGee, in another of the papers presented, expressed his belief that such information can be used to help prevent future suicides.[3]

Recently Brokopp, in discussing what people in the field of suicide will be doing in the present decade, listed seven predictions. His sixth prediction is that more effort will be focused on the families of individuals who have committed suicide. To quote him,

> We now recognize that a person who makes a suicide attempt or who commits suicide . . . is affected in his act by those who surround him and that he deeply affects them. When, for example, suicide does take place, the scars that it leaves

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[1]Ronald W. Maris et al., "Education and Training in Suicidology for the Seventies" (draft of chapter in a book to be published in 1970), p. 13.

[2]Norman Farberow, "Research in Suicide" (paper delivered at the Phoenix conference of the NIMH: "Suicide in the Seventies," 1970), p. 45.

[3]Richard K. McGee, "The Delivery of Suicide Prevention Services" (paper presented at the Phoenix conference of the NIMH: "Suicide in the Seventies," 1970), pp. 6-7.

> in the family and significant friends are profound and require the assistance of people who are specifically trained to work in this type of situation.[4]

Cain and Fast, who are working in the area of the effect of suicide on the survivors, state,

> . . . the implicit interpersonal tugs and pulls of the suicidal person's general presuicidal behavior and ultimate suicidal act have profound effects upon his actual external objects--effects lasting long after the suicidal act--which virtually cry out for study and intervention.[5]

All of the aforementioned authors (plus other writers in various fields) are pointing to the need for research and therapeutic intervention techniques with suicide survivors. All realize that the suicide's family has a high suicide risk and needs help of some sort. Yet for some reason little research has been done on the grief responses of suicide survivors. The great bulk of the work in this area has been in the form of 'psychological autopsies' which are done fairly soon after the death, studies of children who have lost a parent by suicide, or impressionistic studies by therapists of clients who have lost parents or spouses by suicide. Furthermore, these studies have been made by suicidologists, psychiatrists and

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[4]Gene W. Brokopp, "Seven Predictions for Suicide Prevention in the Seventies," Crisis Intervention II:1 (1970), 7.

[5]Albert C. Cain and Irene Fast, "The Legacy of Suicide: Observations on the Pathogenic Impact of Suicide Upon Marital Partners," Psychiatry XXIX:4 (1966), 406-411.

psychologists; nothing of any significance is known to have been done by pastoral counselors. This lack of work by pastoral counselors is quite surprising since suicide, death and grief involve religious questions and are common occurrances which the minister has to deal with.

Thus the goal of this study was to raise a few of the facts and issues regarding the experience of the suicide survivor. To be specific, it is exploratory research that raises many of the questions a pastoral counselor would likely want answered concerning the grief responses of middle-aged spouses reacting to the loss of their husbands or wives. It does not deal just with those deemed to be having extensive trouble in their grief, therefore coming to the attention of the pastoral counselor. Rather, it is a study of two random-sampled groups from the general population. Most of the subjects do not feel they are having enough trouble with their grief to cause them to go to a counselor. The purpose then is to determine how, in general, the 'normal' middle-aged suicide and non-suicide survivors respond to the death of their husbands or wives.

II. BASIC HYPOTHESIS

For research purposes one basic hypothesis was developed, along with a series of specific expectations which spell out the hypothesis more clearly. The basic hypothesis is: The total pattern of the grief responses of suicide spouses will tend to be more disturbed than the grief responses of non-suicide spouses.

Specifically, the basic hypothesis indicates that suicide spouses will feel more lonely and alienated from society, less involved in church, and will not hold their religious beliefs as strongly as non-suicide spouses. They will not have as high an estimation of their marriage with the deceased (i.e. that it was not as intimate, not as 'good' a marriage) as the non-suicide group. The suicide spouses will be more depressed and angry, feel more guilt, and have more suicide ideation and behavior than the non-suicide spouses. In general, the suicide spouse will feel more restricted, both inwardly and outwardly. In summary, the suicide spouses will appear emotionally more pathological (to use medical terminology) since the death than non-suicide spouses.

III. DELIMITATION

Although the purpose of the present research was to accomplish an exploratory overview of how the suicide survivor responds to the death of a husband or wife, it had to be narrowed in several ways to make the results more valid.

For the purposes of narrowing, all single people, divorced or separated spouses, parents of the victim, spouses of those deceased who were over 49 or under 30 years of age, Negro, Mexican-American or other non-white ethnic groups, and combination suicide-homicide cases, were not included. The response of children to the loss of a parent was also omitted, although it would have been interesting to study.

The research on suicide survivors reported here is a cross-sectional retrospective study rather than a longitudinal study. It covers several different aspects of the grief response rather than focusing in depth on one reaction (e. g. the factor of depression, or religious involvement, etc.). It also does not deal with the factors involved in remarriage of the survivors.

Nor was this to be a definitive study of what the minister should do in his pastoral care of the family which has suffered a loss by suicide, but rather it was an exploration of how survivors react

to the crisis of the loss and what resources they have (or have not) used. The focus of the exploration, although geared mainly toward the ministry of pastors, is also aimed at giving other helping professionals an understanding of the suicide survivor. In other words, the purpose of the study is to learn about the response of the spouse to suicide, as compared to the response of a non-suicide survivor, so that the minister (and others in helping professions) can be better prepared when faced with this crisis in his congregation.

IV. DEFINITIONS OF TERMS

Suicide. The definition of suicide offered by Shneidman is quoted:

> As a beginning, a straightforward definition of suicide might read: "Suicide is the human act of self-inflicted, self-intentioned cessation." At least five points are to be noted in this brief definition: (1) it states that suicide is a human act; (2) it combines both the decedent's conscious wish to be dead and his actions to carry out that wish; (3) it implies that the motivations of the deceased may have to be inferred and his behaviors interpreted by others, using such evidence as a suicide note, spoken testimony, or retrospective reconstruction of the victim's intentions; (4) it states that the goal of the action relates to death, rather than to self-injury, self-mutilation, inimical or self-reducing behaviors; and (5) it focuses on the concept of cessation--the final stopping or naughtment of the individual's conscious introspective life.[6]

It might be noted that, unless stated otherwise, this paper refers to those who have completed the act of suicide, not those who are threatening to or talking about it, or who have attempted to take their lives. The term suicidal will be used rather indiscriminately to refer to all people who it is determined have definite tendencies to kill themselves in the near future.

Spouse. This term will refer to the husband or wife of the person who has died. He will have been living with the deceased at the time of death, and therefore not have been separated or divorced.

Resources. The use of this term will refer to those persons, institutions, or organizations which an individual might draw upon for help and solace in the time of grief. Using the resources available to him would tend to help a person work through his grief reaction.

Grief reaction. The term grief reaction refers to the psychological response of a mourning person to the loss of a loved one by death. There are two important sides of this definition: one, it is a loss; and two, the person lost is a love (or need-

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[6]Edwin S. Shneidman, "Suicidal Phenomena: Their Definition and Classification" (Los Angeles: Suicide Prevention Center). (Mimeographed.)

satisfying) object. It amounts to the way the survivors reorient their lives without the deceased. The seven phases of the grief reaction, which have been previously developed by the author, are included in Appendix I.

Stalemated grief reaction. A stalemated grief reaction is the psychological response of the bereaved which is considerably more disturbed than normal. The word stalemated indicates that the disturbed grief reaction is usually manifested by one characteristic of the phases of grief becoming blocked (e.g. constant crying, or guilt, or continual festering hostility). The result is an unresolved grief where the individual is not able to work through that which is blocked.

Grief response. The term is used in this paper as a more general term than grief reaction. The latter refers to the psychological response to the loss; whereas grief response includes not only the emotional aspects of the grief reaction, but also how the survivor reacts financially, what resources he uses, his church attendance (or lack of it), his changing religious beliefs, his work record, etc. In other words, it includes the behavioral and social changes he makes in reaction to the grief as well as the emotional changes. The focus of the present research is the broader grief

response, and not just the grief reaction.

Crisis. The three conditions which constitute a crisis, as indicated by Caplan, are: (1) a severe precipitating stress; (2) extensive emotional arousal; and (3) the pressure to resolve the dissonance caused by the stress and return to homeostasis.

Crisis intervention. This refers to the relatively recent method of aiding people to cope with emotionally decisive moments in their lives (crises). It involves a helper in three activities: (1) developing a relationship with the individual in crisis; (2) focusing in on the central problem and alternative ways of dealing with it; and (3) helping him to develop and initiate a plan of action.

V. ORGANIZATION OF THE REST OF THE DISSERTATION

The remainder of the dissertation is organized to verify the basic hypothesis and to provide further findings which are related to grief reactions and suicide but not directly related to the hypothesis.

Chapter Two includes a review of the literature on the grief responses of suicide survivors and related issues. The third chapter explains the methodology used in verifying the basic hypothesis. It discusses sampling, the development of the grief

inventory, the interviews, and what statistical procedures were used.

Chapter Four embodies the statistical findings related to the basic hypothesis. It gives a series of expectations that were offshoots of the basic hypothesis and indicates which are significant at at least a level of .05.

The fifth chapter contains the findings of the interviews and other statistical tests, most of which do not relate to the basic hypothesis. This chapter, although not integral to the verification of the research hypothesis, is important for a greater understanding of grief.

Chapter Six discusses the results contained in Chapters Four and Five from the standpoint of pastoral care and pastoral counseling. The final chapter includes a summary of the findings of the research and conclusions drawn from them, as well as suggestions for further research.

CHAPTER II

REVIEW OF THE LITERATURE

A substantial amount of literature exists in the field of suicide. A considerable amount has also been written concerning grief. Paradoxically, however, little research or writing has focused on the grief responses of suicide survivors--the purpose of the present study. As was suggested in Chapter One, the majority of what has been written on grief reactions of suicide survivors has been in the form of 'psychological autopsies' performed fairly soon after the death, studies of children's reaction to the loss of a parent by suicide, and impressionistic studies of clients in therapy who have lost parents or spouses by suicide.

The purpose of the present chapter is to review the literature which focuses on the grief of suicide survivors. Several other closely related articles will also be mentioned.

The reader who is interested in greater information on suicide in general is referred to the review of literature chapter in Brown's Ph.D. dissertation[1] or to Beall's article, "The Dynamics

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[1] Timothy Brown, "The Judgment of Suicide Lethality: A Comparison of Judgment Obtained Under Contrived Versus Natural Conditions" (unpublished Ph.D. thesis, The University of Oregon, 1970).

of Suicide: A Review of the Literature 1897-1965."[2] Also helpful is Farberow's article, "Research in Suicide."[3] For a complete listing of the works on suicide the reader is referred to the bibliography recently completed by Farberow.[4]

For a thorough review of the literature on grief, Switzer's dissertation is invaluable. It includes the works of pastoral counselors in the field of grief.[5] Siggins' article, "Mourning: A Critical Survey of the Literature," is especially useful for individuals interested in psychoanalytic conceptions of death.[6] Kalish has also written a thorough bibliography in the area of death and bereavement.[7]

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[2]Lynnette Beall, "The Dynamics of Suicide: A Review of the Literature 1897-1965," Bulletin of Suicidology (March, 1969), 2-16.

[3]Norman L. Farberow, "Research in Suicide" (paper delivered at the Phoenix conference of the NIMH: "Suicide in the Seventies," 1970).

[4]Norman L. Farberow, Bibliography on Suicide and Suicide Prevention (Washington, D.C.: National Clearinghouse for Mental Health Information, Public Health Service Publication #1979, 1969).

[5]D. K. Switzer, "A Psychodynamic Analysis of Grief in the Context of an Interpersonal Theory of the Self" (unpublished Th.D. thesis, School of Theology at Claremont, Claremont, California, 1966).

[6]Lorraine Siggins, "Mourning: A Critical Survey of the Literature," International Journal of Psychiatry III:5 (1967), 418-438.

[7]Richard A. Kalish, "Death and Bereavement: A Bibliography," Journal of Human Relations XIII:1 (1965), 118-141.

The remainder of Chapter Two will first review several articles which do not deal directly with the subject matter but which are closely related and served as a basis for the present study. Secondly, the articles that deal with the suicide survivors' grief reactions will be included.

I. LITERATURE NOT DIRECTLY RELATED TO SUICIDE GRIEF REACTIONS

The Psychological Autopsy in Suicide Studies.

Several articles have been written which describe the psychological autopsy. Theodore Curphey's article in The Cry For Help;[8] Weisman's article, "The Psychological Autopsy and the Potential Suicide";[9] the panel presentation discussed by Pretzel and others in "Psychological Autopsy";[10] and Weisman and Kastenbaum's article entitled "The Psychological Autopsy: A Study of the Terminal

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[8]Theodore J. Curphey, "The Role of the Social Scientist in the Medicolegal Certification of Death from Suicide," The Cry for Help, Norman L. Farberow and Edwin S. Shneidman, editors (New York: McGraw-Hill, 1965), pp. 118-128.

[9]Avery D. Weisman, "The Psychological Autopsy and the Potential Suicide," Bulletin of Suicidology (December, 1967), 15-24.

[10]Paul W. Pretzel et al., "Psychological Autopsy" (verbatim record of a panel discussion at Suicide Prevention Center staff meeting, Los Angeles, March 21, 1969).

Phase of Life"[11] are four of many sources for information on the method of the psychological autopsy and its value in suicide studies.

The psychological autopsy is a method of improved suicide reporting which was originated by Theodore Curphey, who at the time he developed it was Chief Medical Examiner-Coroner of Los Angeles County. Farberow and Shneidman were also instrumental in the development of the psychological autopsy. Since it is known that suicidal individuals usually leave clues to their intentions before they act, the "death investigative teams" are frequently able to uncover the true cause of death. Their primary purpose is to understand the circumstances in which the individual met his death.

The psychological autopsy has been used in the last several years for more than just determining the actual cause of death. It has also been used to study the final events preceding the suicide of an individual. Farberow and Simon in their article, "A Suicide Tale of Two Cities: An Intercultural Study," use the psychological autopsy to study the dynamics which led to actual suicides. The study was conducted in Los Angeles and in Vienna, Austria.[12]

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[11]Avery D. Weisman and R. Kastenbaum, "The Psychological Autopsy: A Study of the Terminal Phase of Life," Community Mental Health Monographs (New York: Columbia University Press, 1968).

[12]Norman L. Farberow and Maria D. Simon, "A Suicide Tale of Two Cities: An Intercultural Study" (Los Angeles: Suicide Prevention Center). (Mimeographed.)

The Farberow and Simon study, while it does not deal directly with grief responses, yields some interesting data which relate to the causes of suicide. It suggests that some of the stresses (e.g. a recent loss, illness, physical and emotional exhaustion, etc.) which lead to suicide are fairly universal. There are specific stresses which are peculiar to each society--in Vienna the suicide victims studied were more isolated and alienated from the rest of society than in Los Angeles, and interpersonal problems tended to be mentioned in the Los Angeles subjects more frequently. However, a general absence of social cohesion and communication was present in suicides of both cities, even with the subjects who had a family living with them. To quote the article, "It was striking to note how little spouses knew about the thoughts, hopes, aspirations and problems of their partners."[13] Farberow and Simon's study is an example of the kind of data which can be gleaned from the psychological autopsy.

Grief Responses.

Two articles and a book are worth mentioning which, like the psychological autopsy, do not deal with the grief response of suicide spouses, but were helpful for this study from the area of grief.

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[13] Ibid., p. 19.

Lindemann's classic article on the management of grief is still valuable and is quoted in almost all of the works on grief which were read. In the article Lindemann differentiates between normal and morbid grief reactions. The disruptions of the normal grief reaction which make it a morbid one are caused by either a delay in the beginning of the grief or a distorted reaction, i.e. one that is characterized by any of the following: (1) overactivity without a sense of loss; (2) the acquisition of symptoms belonging to the last illness of the deceased; (3) a recognized medical disease (such as ulcerative colitis or asthma); (4) alteration in relationships with friends and relatives; (5) furious hostility; (6) a lasting loss of patterns of social interaction; (8) a large amount of activities that are detrimental to the survivor's own social or economic existence; and (9) agitated depression.[14]

Clayton, Desmarais, and Winokur's study of normal bereavement is probably the best work on normal grief from an empirical standpoint. They interviewed relatives of a deceased person to determine their common symptoms of grief. Only three

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[14]Erich Lindemann, "Symptomatology and Management of Acute Grief," Pastoral Psychology XIV:36 (September, 1963), 8-18.

symptoms occurred in over one-half of the subjects--depressed mood, sleep disturbance, and crying.[15]

Marris's book, Widows and Their Families, reports his study of 12 years ago on the adjustment of London widows (widowers were not included in the study) to their spouses' death. Although the research methodology leaves something to be desired (the interviews were not systematic), it was one of the first attempts by a researcher to make a statistical study. Marris lists five reactions which occurred in most of the subjects: (1) lasting deterioration in health; (2) difficulty in sleeping; (3) loss of contact with reality; (4) withdrawal; and (5) hostility.[16]

The difficulty with both Marris's and Lindemann's studies (unlike that of Clayton, et al.) is that the use of nonsystematic interviews makes statements about the prevalence of any symptoms in bereavement difficult to evaluate.

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[15]Paula Clayton, Lynn Desmarais, and George Winokur, "A Study of Normal Bereavement," American Journal of Psychiatry CXXV:2 (1968), 168-178.

[16]P. Marris, Widows and Their Families (London: Routledge & Kegan Paul, 1958).

II. LITERATURE CONCERNING THE GRIEF OF SUICIDE SURVIVORS

In the following paragraphs the review of the literature on the grief of suicide survivors will be organized as follows. First, general articles dealing with suicide survivors and their grief reactions will be reviewed. Then articles focusing on the child's reaction to a parent's suicide and the parent's reaction to a son's or daughter's suicide will be discussed. Finally an article by Cain and Fast focusing on the spouse's reaction to the suicide of a mate will be evaluated.

General Articles.

Farberow, in his discussion of the psychology of survivors, indicates that suicide has a tremendous impact on the survivors, whether or not it is an inter- or intrapersonal type of suicide. He suggests that the following may be the feelings and reactions of those close to the individual who committed suicide: (1) intense feeling of loss and grief; (2) anger; (3) guilt, shame or embarrassment; (4) feelings of failure or inadequacy in not helping the individual who committed suicide enough; (5) feelings of relief from the constant nagging demands of the deceased; (6) feelings of desertion--especially in children; (7) ambivalence; (8) doubts and

self-questioning by the survivor if enough was done for the deceased; (9) denial that the suicide occurred; and (10) impulses toward suicide in the survivor himself.[17]

Goldberg and Mudd wrote on "The Effects of Suicidal Behavior Upon Marriage and the Family" in Suicidal Behaviors. They indicate that the grief reactions of suicide survivors are greatly marked by either anger or guilt, or both. Also the feeling of being abandoned and deserted is frequently present. Goldberg and Mudd further suggest that the guilt can take the form of self-punishment by never marrying again, or by not allowing oneself any close relationships.[18]

Pretzel, a pastoral counselor and clinical psychologist, indicates in "The Role of the Clergyman in Suicide Prevention" that the suicide survivor may experience the following feelings: bewilderment, guilt, shame, anger, self-recrimination, and possibly even suicidal ideation himself.[19] Pretzel suggests four services

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[17]Norman L. Farberow, "The Psychology of Suicide" (Los Angeles: Suicide Prevention Center). (Mimeographed.)

[18]Martin Goldberg and Emily H. Mudd, "The Effects of Suicidal Behavior Upon Marriage and the Family," Suicidal Behaviors, H. L. P. Resnik, editor (Boston: Little Brown & Co., 1968), pp. 348-356.

[19]Paul W. Pretzel, "The Role of the Clergyman in Suicide Prevention" (Los Angeles: Suicide Prevention Center), pp. 10-11. (Mimeographed.)

which the clergyman can perform at such a time. First, he can work closely with the family, encouraging them to deal openly with their feelings. Secondly, the clergyman can refer to someone else those individuals who need professional care. Thirdly, the funeral can be an opportunity for the minister to help the members of the community as a whole in handling their feelings about suicide. Finally, the clergyman can remain in contact with the suicide's family for many months after the death, since some aspects of the grief reaction do not appear immediately in the case of suicide survivors.[20]

Lindemann and Greer were among the first individuals to write on the grief of suicide survivors. They suggest several different aspects which characterize the grief of the survivor. The suicide survivor looks for a scapegoat and frequently finds one within the family--often a child. Lindemann and Greer indicate that in the suicide grief there is a triple loss--death, rejection, and disillusionment. A sense of shame also goes along with a suicidal death. It seems to shake the equilibrium of the survivor's image of himself --he asks himself "what in me caused him to do it." Guilt, depression and anger are further components of the suicide survivor's

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[20] Ibid.

grief; sometimes the anger is turned in on himself and can occur as suicidal activity. One of the most important comments of Lindemann and Greer is that the suicide survivor's grief reaction is likely to get 'stuck.' This stalemated grief can cause the individual to live many years in a state of cold isolation, unable to become close to others interpersonally.[21]

The Child's Reaction.

The majority of the work on the grief reactions of suicide survivors has been aimed at the child's reaction to the loss of a parent by suicide.

Cain and Fast have written several articles on the grief of suicide survivors. Two of the articles deal with the grief reaction of a child for his mother or father.[22, 23] They indicate that the child is frequently involved in the suicide in a number of ways, such

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[21]Erich Lindemann and Ina M. Greer, "A Study of Grief: Emotional Responses to Suicide," Pastoral Psychology IV (1953), 9-13.

[22]Albert C. Cain and Irene Fast, "A Clinical Study of Some Aspects of the Psychological Importance of Parent Suicide Upon Children," American Journal of Orthopsychiatry XXXV:2 (1965), 318-319.

[23]Cain and Fast, "Children's Disturbed Reactions to Parent Suicide," American Journal of Orthopsychiatry XXXVI:5 (1966), 873-880.

as a suicide occurring in the middle of a family fight over the child; a suicide directly precipitated by the child, such as by his misbehavior; a suicide in which the child was told to watch the potential suicide victim and perhaps even to stop any suicide attempts; occurrences where the child was aware of the parent's preparation to commit suicide but told no one; instances where the surviving parent knew of the suicide attempt and did nothing except to send the child to "check if Mom's all right"; and examples of the child unwittingly assisting the parent in the suicide act.

Cain and Fast, although maintaining that the children's reactions were highly individual, note two factors in the suicidal death's effect on the child. The first is the severity of the child's guilt about the death. This guilt can take the form of depression, masochism, guilt-ridden obsessive ideation, the externalization of a harsh superego, self-destructiveness, and reactive ultra-goodness. The second factor is the surviving parent's refusal to tell the child that the death was a suicide. Cain and Fast maintain that the majority of the children knew it was a suicide without the parents telling them. As a result,

> . . . the children clearly received the parental message or even threat that they must <u>not</u> <u>know</u> about the suicide. . . . the parent is genuinely convinced the child knows nothing of the suicide, yet the child often knows the most intimate details of the suicide.[24]

The child is often told that the death was caused by illness or an accident.

Warren in a brief article analyzes the response of the child of a suicide victim in traditional Freudian categories. He states that frequently the emotional development of the child is arrested at his age level at the time of the suicide. Warren believes the child's unconscious wish to remain his age at the time of parental suicide is caused by his desire to be recognized in heaven by the deceased parent, and/or the fear that he will commit suicide himself when he reaches the parent's age. Thus to remain a child is to live.[25]

Beukenkamp, in a study of present and past members of some of his therapy groups, found that the suicidal death of a parent seemed to affect the child in such a way that as he grew up he was resistant to marriage. He maintains that if a father commits suicide and the child chooses the father as his exclusive identification figure, then the child may unconsciously resist getting married.[26]

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[24]Cain and Fast, "A Clinical Study . . .," pp. 318-319.

[25]M. Warren, "Psychologic Effects of Parental Suicide in Surviving Children," Excerpta Medica Series 117 (1966), 433-434.

[26]Cornelius Beukenkamp, "Parental Suicide as a Source of Resistance to Marriage," International Journal of Group Psychotherapy II (1961), 204-208.

Lindemann, Vaughan and McGinnis discuss the preventive therapeutic intervention in the case of a four-year-old child who lost his father by suicide. The article does not specifically deal with the effects of suicide on the survivor. Rather it shows how a social worker helped the mother to weather the grief period, which " . . . led to a situation where she [the mother] no longer needed to use her child as an identification object with her dead husband."[27] The working through of the grief and the aspect of suicide helped to prevent what could have been in future years an emotionally dangerous situation for the child.

In a chapter of a book now in press, Dorpat also deals with the effects of parental suicide on surviving children who were later treated as adults in psychotherapy and psychoanalysis. The study of 17 clients found the following responses to their grief: (1) guilt over the parental suicide; (2) morbid preoccupation with the suicide; (3) self-destructive behavior; (4) depression; (5) absence of grief; and (6) arresting of specific aspects of ego, superego and libidinal development. Dorpat discloses that over half of his subjects lost both parents by death, separation or divorce, either prior to or

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[27]Erich Lindemann, W. T. Vaughan, and Manon McGinnis, "Preventive Intervention in a Four-Year-Old Child Whose Father Committed Suicide," Emotional Problems of Early Childhood, Gerald Kaplan, editor (New York: Basic Books, 1955), pp. 5-30.

within one year after the suicidal death. He further states that the relatives of the child failed to supply the emotional support the child needed and did not provide sufficient opportunities for him to express his grief.[28]

The Parent's Reaction.

The parent's reaction to the suicide of a child has also been studied to some extent. Whitis describes therapeutic intervention in a family whose 13-year-old son committed suicide six months prior to the family entering therapy. Whitis states,

> Working with this family demonstrated for us that a child's death by suicide . . . has the potential for a highly pathologenic legacy for the bereaved. . . . The need for the psychotherapeutic work with the acutely bereaved seems indicated as does the work done in actual suicide prevention.[29]

Herzog and Resnik have studied the families of adolescents who committed suicide in 1965-1966 in Philadelphia. They note frequent family disruption among the surviving parents. At the time of death three of the seven parents were either separated, divorced, or married for the second time. Herzog and Resnik believe the immediate reaction of the parents to the suicidal death

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[28]Theodore L. Dorpat, "Psychological Effects of Parental Suicide on Surviving Children" (chapter of a forthcoming book).

[29]Peter R. Whitis, "The Legacy of a Child's Suicide," Family Process VII:2 (September, 1968), 159-169.

of a child is anger, denial of the suicide, guilt, and depression. An interesting finding from this research is that the surviving parents did not want more children. This and other signs indicate that the families were paralyzed in their grief. Herzog and Resnik also note that,

> Almost all of the parents interviewed stated that they would have appreciated the help of a professionally trained person who could have immediately talked with them about their feelings at the time of the suicide.[30]

One family in the study was able to find such a person; they turned to their family minister.

The Spouse's Reaction.

Finally, there is one article which focuses specifically on the subject of this dissertation: the grief response of the suicide spouse. Cain and Fast report in "The Legacy of Suicide" some observations they have made regarding the spouse's reaction to the suicide of a mate. (The original study which this article was based on was of children of a suicide, reported earlier in this chapter.)

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[30]A. Herzog and H. L. P. Resnik, "A Clinical Study of Parental Response to Adolescent Death by Suicide," Suicide and Its Prevention: Proceedings of the Fourth International Conference for Suicide Prevention, Norman L. Farberow, editor (Los Angeles: Delmar Publishing Co., 1968), pp. 381-390.

Cain and Fast describe five recurring patterns in the surviving suicide spouse. In the first place, suicide spouses are trying to make reparations for past 'sins.' Of those who have remarried, Cain and Fast state,

> The choice of the new spouse was almost totally dominated by a defensive effort to give, nurture, repair, and undo, and the bereaved spouse was attempting to define himself, in the face of past suicide guilt and accusations, as good, as loving, and most of all, as not destructive.[31]

The second pattern was what Cain and Fast described as a "near fanaticism" with "world rescue." This fanaticism covered a variety of plans by some surviving spouses such as curing cancer and innoculating against mental illness.

A third pattern was open self-destructive feelings and behavior. This pattern was reflected in many of the subjects as suicide ideation or behavior.

Fourthly, some of those suicide spouses who remarried used the new marriage partner to purge their strong superego pressures by acting out with the new mate the grievances, accusations and complaints (real and imagined) of their previous

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[31]Albert C. Cain and Irene Fast, "The Legacy of Suicide: Observations on the Pathogenic Impact of Suicide Upon Marital Partners," Psychiatry XXIX:4 (1966), 406-411.

spouses. To quote the authors, "The fierce repetitiveness of these accusations, condemnations, and criticisms, matched only by their irrationality, made a virtual nightmare of the new marriage."[32]

The final pattern was noted in a small subgroup of the spouses who appeared to be attracted to suicidal individuals as marriage partners. Cain and Fast state, "It appeared that these persons used marital partners or other relationships to vicariously act out their own suicidal fantasies."[33]

SUMMARY

The present chapter indicates that although there are many articles about suicide and a considerable number of articles on grief, there are few on the grief responses of suicide survivors. Discussing this lack Cain and Fast state,

> In this area [the effect of suicide on survivors], the older medical-psychiatric literature supplies little more than intriguing tales of identical suicides within families (leading some early writers to a hereditary concept of suicide), and the more recent literature adds only some studies indicating a high incidence of past suicides in the families of psychiatric patients who themselves commit suicide.[34]

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[32] Ibid., p. 410.

[33] Ibid.

[34] Ibid., p. 407.

A problem with many of the aforementioned articles on the suicide spouse's grief is that they are based mainly on clinical populations. Furthermore, they represent very little statistical work. The field of the study of suicide spouses is still wide open to the researcher.

Many different aspects of the suicide survivor's grief reaction were presented by the literature discussed in this chapter. Those which appear important are as follows: suppressed or repressed grief reactions; guilt; the conspiracy of silence both within and outside of the immediate family; reparations being made in various ways by the survivors; denial that a suicide occurred; feelings of desertion; suicide ideation and behavior in the survivor; intense anger; feelings of failure and inadequacy; preoccupation with the death and the suicidal nature of the death; self-destructive impulses; "world rescue" impulses and behavior; the arrest of certain aspects of the psychosocial development of the survivor; and finally, depression.

CHAPTER III

METHODOLOGY

I. THE LOCALE AND THE SAMPLE

Where the Sample was Taken.

It was decided that, because of the willingness of the Suicide Prevention Center of Los Angeles to allow the use of its files on completed suicides in Los Angeles County, all of Los Angeles County would be the location of the sample. Los Angeles County is over 95% urban, and therefore the study is on how urban spouses in Southern California respond to grief.

How Sampled and Who Constituted the Sample.

Two groups of 60 individuals each were sampled out of the total populations of their categories. Half (30) were male and half female in each of the two groups.

The year 1968 was chosen as the year that would be studied, for several reasons. First, the grief reactions would be far enough along to indicate if one group was having more difficulty with a specific area of the grief response than the other. Secondly, in 1968 the Suicide Prevention Center had more complete records than in previous years. Thirdly, the records of more recent deaths

were not complete enough for this research. Finally, choosing subjects whose spouses had died in a period of over one year's duration would further complicate the study. At the time the grief inventory was filled out by the subjects, the age of the grief period was from one to two years.

The suicide sample was selected from the records of the Suicide Prevention Center. At the time the sampling was made (summer, 1969) the records were still not complete for the latter half of 1968. There were records of deaths for all months of the year 1968, but not as many had passed through the legal and bureaucratic channels for the latter months. A breakdown of the months of the deaths can be found in Appendix A.

The non-suicide group was obtained from the Bureau of Records: Death Certificates, Los Angeles County. Death certificates are photographed on microfilm cards, 50 certificates to a card.

The criteria for the selection of both samples were as follows: (1) the deceased died in 1968; (2) the age of the deceased was between 30 and 49 years at the time of death; (3) the deceased was married; (4) the deceased was caucasian; (5) the survivor had an address and/or a telephone number listed; (6) the survivor must have lived in Los Angeles County at the time of death; (7) the

survivor was living with the deceased at the time of death, i.e., not separated or divorced; (8) no homicides or homicide-suicide combinations, or undecided classifications of deaths, were included.

No control was made for what some theorists have alleged to be "suicidogenic" aspects in the spouses of suicidal families. There are confusing results in the little research that has been done in this area. Peck's study, for example, tested "double bind" communication in suicidal families.[1] He found that only 25% of the couples studied had this double bind communication; it is not known how many families without suicide activity would have it. It is guessed by this author that a control group might have a percentage of double bind communication that would be reasonably close to the suicide group.

The "suicidogenic" aspect is not considered to be very crucial to the results of the present study. This is especially true when it is realized that covert suicide in the non-suicide group has not been controlled for. There may be some balancing of biases here. In other words, it is believed that suicide spouses would be slightly more disturbed individuals prior to the death than non-

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[1]Michael Peck, "The Suicidal Family and the Double Bind" (Los Angeles: Suicide Prevention Center, January 26, 1966). (Mimeographed.)

suicide spouses; however it is believed that this would not markedly affect the results of the present research.

In summary, the members of this survey were early-middle- and middle-aged Caucasian spouses who lived in Los Angeles County at the time of death in 1968. They were separated into two groups --those whose spouses died by suicide and those whose spouses died by non-suicidal means.

II. THE GRIEF INVENTORY

The Development of the Questionnaire.

The questions in the grief inventory were developed through a review of the literature and consultation with experts in the field. From a survey of the literature various aspects of the grief responses were noted and possible questions concerning them were formulated. Also, an evaluation was made of different existing inventories that dealt with the various dynamics of the grief reaction, as to what questions could be used in the present study. Authorities in the field were consulted concerning what they felt ought to be the important dynamics studied, and questions to deal with them.

All of the questions were then compiled and narrowed down to 53 Likert-scale items (plus the demographic questions). The

number of items was reduced by eliminating duplications and by consultation with authorities in the field. Three 'lie' questions from the MMPI were included to determine if in either group there was a tendency toward a 'halo' effect. This did not occur, however.

Pretesting.

The inventory was pretested with a small number of individuals who fitted within the two groups being tested but who had not been included among the 120 subjects. A small proportion of the subjects pretested responded.

The results of the pretest led to a rewording of several Likert-scale questions so that the response would not be skewed to one side. Also, the instructions and several of the demographic items were reworded. The question on suicide was changed to make it more comprehensible.

It was also decided that, because in the pretest only individuals from high income brackets and high educational levels responded, a $5.00 "token honorarium" would be offered to each person who completed the inventory, hopefully to induce individuals from lower economic and educational levels to respond to the questionnaire.

The Administration of the Measuring Instrument.

The subjects were called on the telephone first to ask them if they were willing to participate in the research on grief. They were offered the $5.00 token honorarium, which some accepted and some refused. They were also given the choice of whether they would like to be personally visited, or would prefer to have the questionnaire mailed to them. About 80% chose the latter.

The questionnaire was mailed or taken to the subject's home personally with an accompanying letter of introduction (see Appendix C). If the questionnaire was taken personally, only a few basic inquiries were allowed to be answered by the visitor about the research before the inventory was filled out by the subject. In actuality, very few respondents had any questions to ask of the visitor before the inventory was completed. This was done so that the answers on the questionnaire would not be biased by anything the visitor might say.

For those individuals who did not respond within two weeks after they had been contacted, follow-up calls were made and letters mailed. Two follow-up calls (or letters) were made before the person was considered to have refused.

From the information gleaned out of Suicide Prevention Center files and the death certificates, it was possible to reach only

about 25% of the individuals at the listed addresses and/or telephone numbers. Contacting the rest involved calling the information operator, scouring old telephone directories, calling people with the same last name (if it was an unusual name), driving out to the listed address and talking with neighbors, mailing questionnaires to addresses where no telephone numbers were available, and finally requesting the Department of Motor Vehicles of the State of California to trace down those who could not be contacted by other means.

In tracing down subjects and administering the inventory, mistakes and inaccuracies were found in the records. Addresses were not always correct. Names were sometimes wrong on the death certificates. As a further complication, several of the subjects used aliases. Some dates of death were incorrect and some of the causes of death were questionable to the observer. Undoubtedly there were more errors than were discovered. It was the decision of the author not to correct any of the errors, but to let the errors balance themselves out. It is believed that none of the errors in records affected the research in any appreciable way.

Response Percentage.

Of the 120 subjects, 77.5% (93) were personally contacted by the author. It is known that of the 27 who were not contacted, at

least one (and it is believed two) had left the country. It is also possible that one or two of these 27 may have died since the death of the spouse. It is not known where the rest are presently residing or what they are doing.

Twenty-seven of the remaining 93 subjects refused to participate. Thus 55% of the total group, and 70.9% of those contacted, responded to the questionnaire--35 female and 31 male. The survey began in mid-November, 1969, and by the end of December 90% of the responses were in. The last few filtered in shortly thereafter.

III. THE INTERVIEW

Of the 66 who responded to the questionnaire, eight subjects were selected for intensive interviews. The reason for the interviews was to get an impressionistic understanding of different aspects of the total grief response which were not necessarily contained in the grief inventory. There was a twofold purpose for the interview: (1) to try to comprehend any other aspects of the grief response of the spouse which were not tested in the grief inventory; and (2) to get an idea about what further research could explore. No attempt was made to analyze statistically the data gleaned from the interviews.

Selection of the Subjects.

There was no random method of selection for the subjects of the interviews. Four subjects were selected in each of the two groups, two male and two female. The criteria for selection were: (1) all individuals selected had indicated on the last question of the inventory that they would be willing to talk further with the author; (2) some were selected who evidenced suicidal ideation and some who did not; (3) subjects were selected from different income and educational levels; and (4) some were selected who were religious, and others who were not.

The Process of the Interviews.

Each subject was interviewed a total of two to four hours. An interview schedule (see Appendix E) was used very loosely during the interview. The attempt was to cover at least 95% of the questions included on the schedule. Most of the individuals,after being asked a few preliminary questions, answered the majority of the questions on the schedule before they were asked. The method of interviewing was nondirective. All interviews were taped and transcribed.

IV. STATISTICAL TREATMENT

Various methods were used to determine if the hypothesis was statistically correct.

Chi Square.

The 2x2 X^2 was used on all 53 Likert-scale items, all demographic items, and for several other special items which were used to aid the interpretation of some of the data in Chapter Five.

On the Likert-scale items, columns one through three (those who agreed in varying degrees) were combined. Columns four through six (those who disagreed in varying degrees) were also combined. This was done because the low individual cell contents made a more elaborate X^2 impossible.

The library program CGSCHISQ at the Claremont Colleges Computer Center was used and all items which were indicated to be significant, and which had one cell expected frequency of less than 10, were corrected for continuity.[2]

T Test.

The t test was used for the means of the length of marriage of the suicide and non-suicide groups. It was also used to compare

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[2]Janet T. Spence, et al., Elementary Statistics (New York: Appleton-Century-Crofts, 1968), pp. 205-207.

sudden deaths (onset of illness in four days or less until death) and non-sudden deaths in the non-suicide group.

Factor Analysis.

An orthogonal factor analysis of the 53 Likert-scale items was performed. The five factors which resulted used 38 of the 53 Likert-scale items. All but four of the 38 questions had factor loads greater than .5. See Appendix F for the questions which fit into each factor.

Analysis of Variance.

The program used for analysis of variance was a two-way one with unweighted means procedure for unequal ends. Ten analyses were completed and the suicide vs. non-suicide was always included on one side, and a demographic variable (e.g. Protestant vs. Roman Catholic) was used on the other side. All of the analyses were processed with unequal cells, with the exception of the male vs. female analysis, in which six subjects were eliminated by use of a random number table to obtain equal cells of 15 subjects each. The *F* scores for the suicide and non-suicide variable did not change significantly from one analysis of variance to the next. Therefore, with a lack of AB interactions (with one exception), what resulted was in effect a series of one-way analyses of variance.

The statistical results will be presented accordingly. The Studentized range statistic was used for three items. The Newman-Kuels form was used.

SUMMARY

Chapter Three indicates that the locale of the study was Los Angeles County; that 1968 deaths were used; and that 120 middle-aged subjects were random-sampled into two groups, suicide and non-suicide. The grief inventory was developed to verify the basic hypothesis. Eight subjects were also interviewed to test the hypothesis and to search for other information on grief responses. Finally, three main tests of significance were used to aid in statistically testing the basic hypothesis--$\underline{X^2}$, $\underline{t}$ test, and analysis of variance.

CHAPTER IV

RESULTS AND STATISTICAL ANALYSIS OF FINDINGS RELATED TO THE BASIC HYPOTHESIS

The basic hypothesis being tested is, "The total pattern of the grief responses of suicide spouses will tend to be more disturbed than the grief responses of non-suicide spouses." A series of predictions were formulated from the basic hypothesis. In this chapter each prediction will be stated. The questions which from a standpoint of face validity focus on the predictions will be included in the tables, and whether or not the results are statistically significant will be noted. Appendix H includes a full listing of all 53 Likert-scale items, the total response configuration for each, and the $\underline{X}^2$ value for each.

None of the demographic data proved significantly different between the suicide and non-suicide groups. Both $\underline{X}^2$ and $\underline{t}$ tests were used. (See Appendix G for a complete presentation of the demographic data.) There was not sufficient data to divide the respondents into socioeccnomic classes.

I. CHI SQUARE RESULTS

Prediction 1: Marriage Relationship.

The suicide spouse will not perceive the quality of the marriage relationship at the time of death to have been as 'good' (i.e. not as intimate or happy, 'going downhill'), in comparison to the non-suicide spouse.

Table 1 lists the questions which focus on Prediction 1.

TABLE 1

Marriage Relationship

Question (Question no. in parentheses)	S or N[a]	Agree	Disagree	X^2
Our marriage at the time of death was going 'downhill.' (5)	S	16	19	6.63*
	N	5	26	
I don't completely understand why, but in the last few months before the death of my spouse, we argued and verbally fought a lot. (12)	S	12	23	4.37*
	N	3	28	
My spouse hardly ever confided in me. (15)	S	5	30	0.04
	N	5	26	

[a]Henceforth S will be an abbreviation for spouses whose mates died by committing suicide, and N will represent the spouses whose mates died by non-suicidal means.

* $p < .05$.

The information in Table 1 indicates that in two of the three questions the suicide spouse did not feel as good about the marital relationship at a statistical level of .05. The third question was so skewed to one end that the chance of it indicating significance was very low. Prediction 1 is basically verified.

Prediction 2: Religion and Meaning in Life.

Suicide spouses will not be as involved in organized religion since the death as non-suicide spouses. Religion will not be as much help to them during their grief. They will not find as much meaning in life as non-suicide spouses do.

Prediction 2a. Religion and the church. Table 2 indicates the questions used to verify the portion of Prediction 2 which relates to involvement in religion.

Prediction 2b. Meaning in life. The question in Table 3 was used to verify the prediction that suicide spouses do not find as much meaning in life as do non-suicide spouses.

The data in Tables 2 and 3, plus the questions on church attendance in Appendix G, indicate no significant differences between the two groups. Therefore, Prediction 2 is not proved.

TABLE 2

Religion and the Church

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
I believe I have been more religious since the death of my spouse. (3)	S	15	19	2.38
	N	8	23	
My church has not been of very much help to me in the hard times since my husband/ wife died. (4)	S	22	11	3.48
	N	12	16	
I can take religion or leave it. (25)	S	16	19	0.23
	N	16	15	
Prayer can solve many problems. (26)	S	20	15	1.36
	N	22	9	
The death of my spouse has made me turn to God for help. (11)	S	17	18	0.02
	N	14	16	
God protects from harm all those who really trust in him. (28)	S	18	17	0.48
	N	18	12	

TABLE 3

Meaning in Life

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
Since my spouse died I have not had anything to live for. (13)	S N	4 4	31 26	0.05

Prediction 3: Emotional Reaction to the Loss.

The emotional response to the death of a spouse (technically the grief reaction) will be more disturbed in suicide survivors than in non-suicide survivors.

In the following tables, various aspects of the third prediction are indicated. The questions in Table 4 tested the individual's acceptance of the death.

Prediction 3a. The suicide spouses will perceive from other people a stigma attached to the manner of the husband's or wife's death. They will feel themselves blamed to some degree for their spouse's death.

The two questions listed in Table 5 pertain to the stigma of suicide.

TABLE 4

Emotional Response to the Loss

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
I just can't seem to get over the death of my spouse. (49)	S N	17 13	18 18	0.29
I still have trouble realizing that my spouse is dead. (37)	S N	20 17	15 14	0.04

TABLE 5

The Stigma of Suicide

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
At times I have felt like I was being compelled to move residence because of what some people thought about my spouse's dying. (7)	S N	9 0	26 29	6.69**
I have felt blamed by others to some extent for my spouse's death. (16)	S N	9 1	26 30	5.15*

*$p < .05$.
**$p < .01$.

Prediction 3b. Suicide spouses will exhibit more suicidal ideation and behavior than non-suicide spouses.

The question used to test Prediction 3b was: "Circle any of the following which express your feelings since the death of your husband or wife. Mark 'B' in front of the sentence which expresses your feelings before the death." The responses to this question are indicated in Table 6.

TABLE 6

Suicidal Ideation and Behavior Since the Death

Responses	S	N
Not thought about killing myself at all.	19	22
Thought only a little about killing myself, but not for quite a while.	3	1
Thought about killing myself off and on.	4	0
Thought about killing myself fairly often but have not told anybody.	1	1
Thought a lot about it and told others I felt like killing myself.	0	1
Attempted suicide.	1	0
No answer.	7	6

A 2x2 $\underline{X^2}$ was performed contrasting those who had any suicidal ideation and/or behavior with those who did not. The $\underline{X^2}$ is 2.02, which, though it would tend to verify Prediction 3b, is still statistically non-significant. The second part of the above question ("Mark 'B' in front of the sentence which expresses your feelings before the death.") is not included because 29 of the 66 subjects did not respond to it. Any results it might show would not be reliable.

Prediction 3c. Suicide spouses will feel more anger (directed toward both those around them and their deceased spouses).

The two questions in Table 7 were used to verify Prediction 3c.

TABLE 7

Anger

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
There have been times since he/she died that I have felt mildly irritated or disappointed in him/her. (18)	S	19	16	6.92**
	N	7	24	
Since my spouse died I get annoyed or irritated more easily than I used to. (19)	S	15	20	0.79
	N	10	21	

**$\underline{p} < .01$.

Prediction 3d. Suicide spouses will experience more anxiety and depression during their grief reaction than non-suicide spouses.

Questions 30, 35 and 42, listed in Table 8, were used to test Prediction 3d.

TABLE 8

Anxiety and Depression

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
It does not take me long to get over feeling gloomy. (30)	S	24	11	0.03
	N	23	8	
I feel depressed and very low and miserable most of the time. (42)	S	3	31	0.28
	N	4	27	
I feel pretty generally secure and free from care. (35)	S	20	15	0.62
	N	20	10	

Prediction 3e. Suicide spouses will exhibit more feelings of guilt and self-blame than non-suicide spouses. They will also tend more to feel that they deserve to be punished than the non-suicide spouses.

Table 9 contains the questions from the grief inventory which dealt with Prediction 3e.

TABLE 9

Guilt

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
Although I feel I maybe shouldn't, at times I feel ashamed about the way my husband/wife died. (50)	S	15	19	6.20*
	N	4	27	
Although I don't like to think of it, I feel at times as if I were part of the cause of my spouse's death. (47)	S	18	16	13.88**
	N	3	28	
I often think I should have done more for my spouse before he/she died. (46)	S	22	12	5.54*
	N	11	20	
I feel guilty about some things I said and did before my spouse died. (44)	S	24	11	8.68
	N	10	21	
At times I feel I deserve to be punished. (41)	S	9	26	2.84
	N	3	28	

* $\underline{p} < .05$.
** $\underline{p} < .01$.

Prediction 3f. Suicide spouses will be less open with their feelings and will experience greater loneliness than non-suicide spouses.

The questions in Table 10 were formulated to test Prediction 3f.

TABLE 10

Lack of Openness with Feelings and Loneliness

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
I fear to express my deepest feelings to other people, even those close to me. (45)	S N	11 9	24 22	0.04
I am a more lonely person since the death of my spouse. (20)	S N	26 18	9 13	1.95

Prediction 3g. Suicide spouses will perceive themselves as being less impulsive, more dependent, and more lacking in personal freedom, self-confidence and social respect than will non-suicide spouses.

Five questions were formulated to verify Prediction 3g. Each of the five questions tested a different aspect of Prediction 3g, and yet they are all related to some extent. Table 11 lists the results of Prediction 3g.

The trend of the responses related to all of Prediction 3 is toward verifying the hypothesis, but only specific aspects of the results are statistically significant. Thus a portion of the third prediction is verified.

TABLE 11

Variables in Prediction 3g

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
I refuse to allow myself the slightest self-indulgence or impulsive action. (38)	S N	10 8	25 21	0.01
I feel independent now, not needing to depend on others. (24)	S N	18 19	17 12	0.65
I feel trapped, oppressed, forced to do things I don't want to do. (33)	S N	10 7	25 24	0.31
I am distressed by my weakness and lack of ability, sick of my incompetence. (51)	S N	4 4	31 27	0.03
I am looked upon as being of small or no account in other people's eyes. (31)	S N	3 1	32 29	0.77
I am not as confident about the future as I was before the death of my spouse. (22)	S N	20 12	15 19	2.24

Suicide spouses tend to perceive a stigma attached to the manner of their mates' death and feel blamed to some extent for the death of their husbands or wives. Suicide spouses also evidence more anger focused at the deceased than do non-suicide spouses.

They do not have a greater amount of general irritation and anger, however. Interestingly enough, they also do not evidence any more anxiety or depression than do the non-suicide spouses. The most obvious difference between the grief reaction of the suicide spouse and the non-suicide spouse is that the suicide spouse feels a greater amount of guilt concerning the deceased.

Prediction 4: Social Involvement and Utilization of Resources.

Suicide spouses will not be as involved socially since the death as non-suicide spouses. They will use fewer resources outside their immediate family in responding to their grief.

The Likert-scale items related to Prediction 4 are indicated in Table 12.

When the subjects were asked whether they had actually had counseling since the death, 10 suicide and 3 non-suicide spouses responded positively, which proved to be nonsignificant (1.71) using the X^2 test. However, 12 suicide and only 2 non-suicide spouses indicated that they had had counseling before the death, which was significant with a X^2 score of 5.74 ($p < .05$.)

Table 13 includes the subjects' responses to the following question: "Circle any of the following which were very helpful in aiding you to adjust to your spouse's death."

TABLE 12

Social Involvement and the Use of Resources

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
I now feel left out of social life more than I used to be. (14)	S	10	25	0.76
	N	12	19	
Friends and relatives don't seem as close to me as they did before my spouse died. (10)	S	12	22	0.03
	N	10	20	
I feel the funeral helped me greatly at the time of his/her death. (6)	S	12	21	0.40
	N	12	15	
I have felt like I (and/or my children) have needed counseling since the death of my spouse. (8)	S	14	20	0.55
	N	10	21	

TABLE 13

Resources

Item[a]	S	N	Total
Yourself	24	19	43[b]
Minister/rabbi/priest	6	8	14
Parental family	15	10	25
Other relatives	11	10	21
Your children	23	19	42[b]
Counselor/psychotherapist	2	0	2
Friends	26	19	45[b]
Prayer, reading the Bible	11	7	18
Church	8	4	12
Family doctor	6	5	11
Social worker	2	0	2
Other professionals	1	2	3
Funeral	4	2	6
No one	3	0	3
Other	4	6	10

[a]Using the chi square, none of the 15 response items in Table 13 were statistically significant.

[b]Items which over half of the respondents felt were very helpful.

Prediction 4 is not verified statistically. None of the items in Tables 12 or 13 are significantly different between the suicide and non-suicide groups.

Prediction 5: Behavior.

Behavioral expressions of the grief process will tend to be more disturbed in the case of suicide spouses than in the case of

the non-suicide spouses.

Prediction 5a. The suicide spouse will be ill more frequently, have more sleep disturbance, and will use more alcohol and drugs than the non-suicide spouse.

Table 14 lists five questions which tested Prediction 5a.

Prediction 5b. The suicide spouse will cry less and try to avoid sympathy or anything that reminds him of the deceased more than the non-suicide spouse.

Table 15 lists responses dealing with Prediction 5b.

Prediction 5c. The suicide spouse will have a more difficult time raising his children (because of his greater social isolation and more frequent stalemated grief reactions in the children).

Table 16 indicates how the subjects responded to the question of raising children.

The behavioral expressions of the grief response are wide and varied. Of the expressions tested in the grief inventory, there is very little significant difference between the two groups. One variable, illness, is the dramatic exception to this trend. Suicide spouses have considerably more problems with poorer health after the death than do non-suicide spouses. With the exception of illness, Prediction 5 is not verified.

TABLE 14

Illness, and Alcohol and Drug Consumption

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
I have not been as healthy since the death of my spouse (i.e. asthma, rheumatism, colds, rashes, headaches, etc.). (1)	S	19	16	11.85**
	N	4	26	
I feel physically tired much of the time. (40)	S	18	17	3.41
	N	9	22	
I have some trouble sleeping and wake up more tired in the morning than I used to. (39)	S	14	21	0.01
	N	12	19	
I am drinking more alcoholic beverages than before the death. (Check if never have drunk.) (17)	S	12	17	1.49
	N	7	20	
Since the death of my spouse I have been using more drugs (such as tranquilizers, sleeping pills, narcotics, pep pills, etc.). (21)	S	5	29	0.38
	N	3	28	

** $\underline{p} < .01$.

TABLE 15

Prediction 5b

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
I have not cried to speak of since my spouse died. (23)	S N	5 11	30 18	3.55
I try to avoid anything that reminds me of my spouse. (53)	S N	3 2	32 29	0.11

TABLE 16

Raising Children

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
My children have been more difficult to raise since my spouse's death. (Check if no children living with you at time of death.) (9)	S N	13 12	13 11	0.02

There were several other questions in the grief inventory which were not based on predictions, but which were included in

this exploratory research to gain a greater overview of the grief responses of the two groups. Table 17 lists these questions under the general areas which they explored, and their responses. None of them even approached statistical significance.

II. FACTOR ANALYSIS

A factor analysis of the 53 Likert-scale items was completed. Thirty-eight of the items formed five factors. The following are the five factors:

Factor 1: Emotional Acceptance of the Loss.

Factor 1 takes up the various emotions one would include in a definition of the grief reaction--except for guilt, which is Factor 2. Among these emotions are the ability of the individual to accept the loss, physical and/or psychosomatic responses, anger, anxiety, depression, crying, lack of confidence in self and in the future, a feeling of being trapped, and the perceived need for counseling. The variables in Factor 1 have factor loads ranging from .48167 to .74461. The average loading for the 15 variables is .63750. (For a listing of what questions constitute Factor 1 and the other four factors, see Appendix F.)

TABLE 17

Miscellaneous Questions

Question (Question no. in parentheses)	S or N	Agree	Disagree	X^2
Work				
I get a great deal of satisfaction out of my work. (Check if you have not worked full or part time since your spouse died.) (34)	S N	25 25	5 2	1.13
Financial situation				
I have gotten along all right financially since the death of my spouse. (2)	S N	26 27	9 4	1.71
Reaction to consolation				
After a while I got tired of people always trying to console me about my spouse's death. (43)	S N	13 12	20 19	0.00
Scapegoating				
If it weren't for my spouse, I'd be in a lot better shape today in this world. (48)	S N	2 1	32 29	0.23
Beliefs on suicide				
Nothing is worth killing yourself for. (29)	S N	30 28	4 3	0.07
Suicide is morally wrong. (36)	S N	25 24	10 7	0.31

Factor 2: Guilt.

The second factor includes the questions that directly dealt with guilt (four questions), plus a question which measured the respondent's perceived blame from others, a question that tested his perceived lack of social respect, and a question related to his anger (irritation) at the deceased. The factor loadings vary from .46376 to .79878. The average loading is .65639.

Factor 3: Religious and Belief System.

The third factor focuses on the respondent's feelings and beliefs about religion (five of the seven questions included in Factor 3). It also includes the two questions about suicide, one of which is couched in religious/moral jargon. The factor measures the individual's involvement in religious belief, both presently and in reaction to the spouse's death. The factor loads are from .50774 to .79110. The average load is .66647.

Factor 4: Feelings about the Marriage.

Factor 4 is the subject's present evaluation of his marriage relationship with the deceased. It measures how the individual, after at least one year's time, feels about his spouse and their marriage. The factor loads of the fourth factor are .53313, .61591, .65152, and .71905. The average load is .62990.

Factor 5: Meaning and Independent Involvement in Life.

The final factor is a conglomerate of five questions. It measures the respondent's feeling about meaning in life, his sense of loneliness, his feeling of being left out of social life, his feeling of lack of independence, and his sense of needing to be punished. Basically what these questions tested is an individual's feeling of independence and involvement in social life. It also indicates if the person finds meaning in life. The factor loads vary from .48510 to .72294. The average is .60326.

III. ANALYSIS OF VARIANCE

All of the analyses of variance were two-way, with the suicide and non-suicide variable always on one side and the demographic variables on the other. Since the AB interaction was significant in only one item, the continual presentation of the results of the suicide and non-suicide variable would only be duplication and has been omitted. The data are presented as one-way analyses of variance.

Only one of the analyses of variance relates to the basic hypothesis; it is the comparison of suicide and non-suicide for the five factors. For this analysis (which was compared with male and female), six respondents were selected out, by use of a random

number table, to yield four equal cells of 15 respondents each. The results are included in Table 18. The significant items in Table 18 are in actuality identical to the results which were indicated earlier in this chapter in the $\underline{X^2}$ tests.

TABLE 18

Analysis of Variance: Suicide and Non-Suicide

Source	df	MS	F
Factor 1	1, 56	595.43	1.92
Factor 2	1, 56	806.60	18.45**
Factor 3	1, 56	10.42	0.13
Factor 4	1, 56	101.40	4.89*
Factor 5	1, 56	20.42	0.73

*$\underline{p} < .05$.
**$\underline{p} < .01$.

IV. FINDINGS FROM THE OPEN-ENDED QUESTIONS IN THE GRIEF INVENTORY

There were four open-ended questions on the grief inventory, plus a space at the end of the inventory for the respondent to add anything he wished. In the following paragraphs the responses to the questions about the help of the minister, the funeral, meaning in life, and changes in religious practices will be presented.

The Minister.

The response was varied to the question, "Please write on these lines what a rabbi/minister/priest did that aided you in your time of grief. Please also write what he did that was not helpful." A few of the positive and negative comments which seem to express the tenor of the group as a whole are listed below.

"[The] message before and during the funeral was from his heart and helped us all in our loss."

"Made me realize that perhaps all is not lost after all."

"I am very grateful to my church and fellow Christians for their love and understanding."

"Calm encouragement without being maudlin."

"The minister was arranged for through [the funeral parlour]. He called me once and spoke to me briefly, too briefly. The service was too impersonal and too long. He could have been talking about anybody."

"Pushed too hard on follow-up after the funeral."

"No help, he only tried to convert me back to the church."

"He did little other than hold the service."

"Spoke from his heart."

"He was kind and helpful, but not overly so."

"Baptist minister said my husband was taken to punish me and he probably couldn't go to heaven because he had never been baptized!"

To summarize the above comments, the general feeling of the respondents was either neutral or mildly positive toward the minister, although there were some negative comments. There appeared to be no difference between the suicide and non-suicide responses.

Funeral.

The following question about the funeral, "Please write on the back what in the funeral helped you and what did not," also had a varied response. The following are a few of the comments made in response to this question.

"The funeral did make me feel better. . . . Seeing how nice he looked and so very peaceful, I felt slightly relieved."

"I do not feel that the funeral helped me in any way. I was in a state of shock at the time. It was as if it weren't happening to me."

"The funeral home and priest were very helpful. The costs of the funeral and burial were too high."

"I think the funeral was more depressing. I feel they should be abolished completely."

"Over 300 people came to his funeral. This made the children and I feel pretty proud."

" . . . I consider them a barbaric custom, but it is difficult to fly in the face of generally accepted custom. . . . the only good at all was seeing family and friends and absorbing their sympathy and understanding."

"I realized that I would now have to make a new life."

"It was a tribelike ritual, and even though it was closed-coffin, the smell of the flowers, and the smell and look of grief was the most macabre and nauseous experience I've had. The experience clings around one like a musty drape, and death I can cope with, the capitalization I cannot."

The majority of the individuals responding to the question were neutral about the funeral. The funeral seemed to be comforting to some and a gaudy, costly, senseless ritual to others. There appeared to be no dramatic differences in the respondents' attitudes regarding the value of the funeral between the suicide and non-suicide groups.

Meaning in Life.

The question, "Who or what gives you meaning in life?", elicited an interesting result. Twenty of the 27 suicide spouses, and 17 of the 23 non-suicide spouses who responded to this question

gave the same answer: their children. Although some people listed several responses, no other answer came close to this frequency. The responses of work, "myself" or life itself, God or the church, and new wife, husband or fiance, were all clustered as the second choices. The number of individuals naming them was from seven to nine (total of both groups) for each response, none higher. There was no significant difference in the response patterns between the two groups.

Changes in Religious Practices.

Finally, only a few responded to the question, "Have you taken on any new religious practices or joined a different church or denomination since your spouse's death?". The vast majority of the respondents (61 or the 66) indicated no change in religious practices since the death of their spouses. There was no significant difference between the suicide and non-suicide groups.

SUMMARY

The positive findings indicated in this chapter are, first, that the suicide spouse feels considerably more guilt about the death of his spouse than the non-suicide spouse. Secondly, he feels he is being blamed by others to a greater extent. A third finding is that the suicide spouse perceives the quality of the marriage relationship

at the time of death to have been poorer than does the non-suicide spouse. Another finding is that the suicide spouse feels more anger toward the deceased than the non-suicide spouse. In the fifth place, he feels the stigma of suicide, evidenced by his feeling more compelled to move his residence after the death. Finally, the suicide spouse is ill considerably more after the death of the husband or wife, in comparison to the non-suicide spouse. Thus some of the predictions based on the basic hypothesis are verified, as indicated above, while others are not.

CHAPTER V

FURTHER RESULTS

I. FINDINGS FROM THE INTERVIEWS

Intensive interviews were conducted with eight selected individuals who had completed the grief inventory, four suicide and four non-suicide, as explained in detail in Chapter Three. In both the suicide and the non-suicide groups, two women and two men were interviewed.

Statistical verification of hypotheses was not the intent of the intensive interviews. Rather, they served as a method of getting an impressionistic account of some nuances of feeling and behavior that could not be gleaned from the Likert-type scale items. It is difficult to summarize over 225 typed pages of the transcripts of these interviews in a few pages. Yet, several aspects of the grief responses of those who were interviewed appeared to be quite important. These findings will be presented in the following paragraphs.

Phases of Grief.

There seemed to be regular phases which those interviewed went through in their grief. In the first few hours, and off and on

for the following two weeks after the death, the individual went into periods of shock. During this time, one interviewee said, "I felt nothing." Another said she just sat down for several hours and wasn't aware of anything. One man said that after he heard the news he acted as if nothing much had happened. He went to the place where his wife had died and started making arrangements for the body to be removed. He described it as being as if he were acting "automatically," like a robot. Another person said the shock period returned several times during the first few days. At the funeral, she stated, "[It] was like I was watching a movie that I wasn't really in."

The second period in the grief of the interviewees was crying, and/or the influx into their awareness of the full weight of the feelings about the loss. Some of those interviewed described getting hysterical during this period. Others did not behaviorally express it quite as dramatically, but felt it just the same inside. This experience predominated from the first few days through the end of the first or second week. It was usually at a high point around the time of the funeral (either fairly soon before or fairly soon afterwards).

After the funeral was over and acquaintances stopped talking about the deceased, and went on with their business as usual, the

surviving spouse described bouts of depression. These bouts with depression seemed to come and go with diminishing frequency and duration in a normal grief reaction. Anxiety and angry outbursts occurred during this period. Also, guilt began to be felt. In the case of suicide spouses this guilt, although lessening some, was still evident one to two years later, and was still quite strong in several of the individuals interviewed.

The period around the third month seemed to be crucial. It was during this time in their bouts with depression that several of those interviewed indicated they had their suicide thoughts. Some stated that they had had suicide ideation before then, but that it was at about the third month that it appeared to be most dangerous.

Six months after the death appeared to be a turning point in the normal grief, when the survivors who were interviewed said they really began 'coming out of the cloud' and being less troubled by the grief. After one to two years the grieving individuals were still dealing with the loss of their spouses, but there seemed to be some greater relief from the problems tested in Factor 1, beginning at the sixth month.

Children.

A second observation is that friends and relatives rallied around the grieving spouses, but in the subjects interviewed very

little attention was given to the children's grief. The assumption by both the surviving spouse and by the friends and relatives appears to be that the greatest amount of grief is felt by the spouse and that, although the children are sad too, they do not suffer like the spouse. The validity of this popular assumption has not been tested. Dorpat, Cain and Fast, and others have indicated that the problem of grief is greater for the children than is commonly expected. This appears to be especially true in cases of deaths which are particularly troubling to the family.

When the surviving spouses were asked in the interviews how their children reacted to the grief, none of them knew. They said that they never really talked to them about it. Upon further questioning, there appeared to be three ways that the children of those interviewed acted out their grief behaviorally. First, several parents indicated greater amounts of illness in their children. (The adults also reacted psychosomatically during their grief.) The second type of behavioral reaction was for a child to try to take the place of the deceased spouse in the family. One father indicated that his junior high school daughter almost completely took over his wife's duties, to the total exclusion of playing with her friends. When he began to come out of the shock of the grief himself, he realized what was occurring and had to

physically stop her from performing many of these duties until she finally went back to the normal life of a seventh-grader.

The third type of acting-out in the children was to become 'problem' children. One son in his first or second year of college was very troubled by his mother's death, and within six months went from being an A and B student to 'flunking' out of college and drifting aimlessly around the country--his father didn't even know where he was at the time of the interview. One mother indicated that several weeks after her husband died her seven-year-old boy started stealing, and leaving the money he had stolen in places where it would easily be found. She ignored it the first few times but finally confronted him with it. When she asked him what was she going to do with him, " . . . he said, 'You're going to whip me, aren't you,' and he kind of had a smile on his face." After she 'whipped' him, he never acted out his grief in that way again. The mother added, "I think he wanted to be punished. Because--I imagine he felt responsible in some way for the suicidal death of his father ."

Conspiracy of Silence.

Westberg stated, in his little book Good Grief, that Americans " . . . conduct a quiet conspiracy of silence" against

grief.[1] This conspiracy of silence was noted in the interviews. Friends, relatives and business associates stopped talking about the deceased a few weeks after the funeral. Some of the spouses craved for an opportunity to talk about the deceased spouses, while others did not mind much one way or another. Even within the family, the deceased was not remembered or talked about very much; it appeared from the interviews that the children talked about them the most. After a few weeks there did not seem to be much grieving which involved the family as a whole (i.e. a sharing of the grief and a concern and caring for each other in their mutual grief).

Related to the "conspiracy of silence" about death was a striking comment that nearly all of those interviewed made to the author. They indicated that the interview with the author was the first time since their spouses died that they had sat down and talked at any length about it. Several of them expressed that it was helpful and they wished they could have done it sooner.

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[1]Granger E. Westberg, Good Grief (Philadelphia: Fortress Press, 1962), p. 48.

Parental Responsibility.

A fourth observation was that the double responsibility of being both mother and father to the children was more difficult than most of the interviewees had expected. Most of the individuals interviewed said this double responsibility kept them so busy that they had little time for other activities. They stated they were frequently exhausted by these responsibilities. One women put it this way: "Your life naturally I think does change a little but you have more responsibilities, you've got all the grocery shopping to do, you've got all the checks to make out and the bills. If anything comes up you have to go and see about it yourself . . . if anything goes wrong with my car I've got to look around and find a dependable mechanic or someone to fix it nice. . . ."

Relationships with the Opposite Sex.

Another observation was that one of the major factors keeping several of the individuals who were still widowed from remarriage was the fear of losing another spouse and having to go through the grief all over again. This appeared to be a common concern with almost all of those who were not presently considering remarriage. One woman described the feeling that both she and the man she is dating have: " . . . it is the terror in both of us of

loving again, of letting yourself be that wide open, and then going through that hurt." It is possible, although not statistically known, that this feeling may be a common one with many middle-aged widowed persons.

A further hindrance to remarriage was that men seemed to question their manliness after their wives' death. (This questioning was not sensed in the women, but it may have been there in a more subtle way, unknown to the author.) Three of the four men who were interviewed indicated they were afraid at first to associate with single women, widows or divorcees, because they said they did not know how to act. They generally did not want to enter into a dating relationship such as they had had before their first marriage. One man related that he became impotent for period of time after his wife's death.

Several of the spouses who were interviewed also perceived suspicious feelings among their married friends toward them. One older man, speaking in broken English, said, "Because everyone is married and people think if they coming something happen, because I am alone. You know people. But I never was such a man. I never looking for other man's wife, and I never want to."

Reaction to the Death Itself.

A final observation was that most of the individuals, both suicide and non-suicide, in describing the death, indicated that the death was not like what they had expected it to be. In America, besides the fantasy that most people have about what marriage is supposed to be like, there is also the fantasy about what death is to be like. One respondent, whose spouse died after an illness, described her experience this way: "It wasn't what I had visualized --you know, no last words, no beauty. It was horror. The ugliest thing I've ever seen."

There are other observations that could be made, but the above seemed to be the most important. There did not appear to be any graphic differences between the suicide and non-suicide groups which have not already been discussed. Only when the question, "Are you telling your friends how your husband (or wife) died?" was asked were the two groups clearly distinguishable. One spouse was candid with everyone else about her husband's suicide, but the other three were not (each varied with the number of people they would tell).

II. OTHER STATISTICAL RESULTS WHICH DO NOT RELATE TO THE BASIC HYPOTHESIS

In this part of Chapter Five, several further statistical results will be presented which, although they do not relate directly to the basic hypothesis, are important to the student of grief or suicide. Since the variables in this section are not as well controlled as the suicide and non-suicide variables, the findings are more tendentious and must be understood in that light. This is not to say that the results contained herein are irrelevant or baseless. On the contrary, it is the belief of the author that some important findings have resulted which will be presented in the following pages.

Analysis of Variance.

Male-female. In this test six subjects (as previously outlined) were selected out to develop equal cell sizes. The results are listed in Table 19.

Table 19 indicates no significant differences between male and female on any of the five factors. On the religion factor, the greater religiosity of women approaches significance.

TABLE 19

Analysis of Variance: Male and Female

Source	df	MS	F
Factor 1	1, 56	742.09	2.39
Factor 2	1, 56	24.02	0.55
Factor 3	1, 56	294.81	3.64
Factor 4	1, 56	3.27	0.16
Factor 5	1, 56	8.82	0.32

Those attending organizations regularly and those who do not.

The subjects who responded positively to question 8 of the demographic data were compared against those who responded negatively. Table 20 lists the results.

TABLE 20

Analysis of Variance: Attend Organizations

Source	df	MS	F
Factor 1	1, 62	225.95	0.75
Factor 2	1, 62	44.05	0.90
Factor 3	1, 62	458.94	5.92*
Factor 4	1, 62	80.97	3.97*
Factor 5	1, 62	43.74	1.74

*$p < .05$.

Table 20 indicates that those who attend organizations regularly are also more religious. Furthermore, those who attend organizations regularly feel better now about their marriage with the deceased.

Church attendance. The subjects who responded to a or b of question 12 on the first page of the grief inventory were considered regular church attenders. The subjects who marked c or d were considered non-regular church attenders. Table 21 provides the results of the comparison.

TABLE 21

Analysis of Variance: Church Attendance

Source	df	MS	F
Factor 1	1, 62	382.84	1.23
Factor 2	1, 62	116.11	2.44
Factor 3	1, 62	831.12	11.63**
Factor 4	1, 62	1.24	0.06
Factor 5	1, 62	85.34	3.47

** $p < .01$.

Table 21 shows that Factor 3 is significant well beyond the .01 level, which indicates that regular church attenders are more religious.

Length of marriage. In this factor all spouses who had been married 0-10 years, 11-20 years, and 21 years or more, were combined into three groups. The results are listed in Table 22.

TABLE 22

Analysis of Variance: Length of Marriage (0-10, 11-20, 21+)

Source	df	MS	F
Factor 1	2, 60	116.99	0.36
Factor 2	2, 60	32.20	0.63
Factor 3	2, 60	14.41	0.18
Factor 4	2, 60	74.63	3.88*
Factor 5	2, 60	8.19	6.33

* $p < .05$.

Factor 4 is significant, as seen in Table 22. Spouses whose marriages were 10 years or less in duration have a significantly poorer image of the marital relationship. This is especially true in the case of suicide spouses who were married less than 10 years. The Newman-Kuels test was used to determine if the mean of the suicide group (15.58) was significantly different from the other means (19.83, 19.90, 20.46, 21.70, 22.00). The Newman-Kuels test showed a significant difference on only three of the five means.

The suicide mean is therefore not significantly independent from the other means.

Suicidal ideation and behavior. All the respondents who marked b through f on the suicide question were compared with those who indicated that they had had no suicidal ideation or activity since the death (those who marked a). The results are shown in Table 23.

TABLE 23

Analysis of Variance: Suicide Ideation and Behavior

Source	df	MS	F
Factor 1	1, 49	4022.27	23.32**
Factor 2	1, 49	152.31	3.66
Factor 3	1, 49	448.16	5.74*
Factor 4	1, 49	11.72	0.76
Factor 5	1, 49	336.47	17.63**

* $p < .05$.
** $p < .01$.

The results in Table 23 indicate that individuals with suicide ideation and behavior are having a considerably more difficult time in emotionally accepting the loss. The probability of Factor 1 occurring randomly is .0001. The individuals with suicidal

activity are also less religious (Factor 3). The respondents with suicidal ideation and behavior are more lonely and lack meaning in life (Factor 5). This is the only occurrence of Factor 5 being significant in all of the analyses of variance that were performed.

Protestant and Roman Catholic. The responses of the Protestant and Roman Catholic subjects were compared to see if there was any difference in the two. The results are listed in Table 24.

TABLE 24

Analysis of Variance: Roman Catholic and Protestant

Source	df	MS	F
Factor 1	1, 47	22.62	0.07
Factor 2	1, 47	279.01	6.72*
Factor 3	1, 47	15.87	0.24
Factor 4	1, 47	220.17	11.73**
Factor 5	1, 47	12.90	0.49

* $p < .05$.
** $p < .01$.

Table 23 shows that Roman Catholics tend to feel more guilt about their deceased spouses than do Protestants. It also shows that Roman Catholic spouses do not perceive the marital

relationship with the deceased husband or wife as having been as good as do the Protestants.

Remarriage. The subjects who marked b and e (remarried and widowed, respectively) on question 2 of the demographic data were compared to determine if marrying again can help one in his grief. The results are indicated in Table 25.

TABLE 25

Analysis of Variance: Remarriage

Source	df	MS	F
Factor 1	56, 1	2821.00	10.16**
Factor 2	56, 1	36.62	0.74
Factor 3	56, 1	17.04	0.20
Factor 4	56, 1	96.43	4.82*
Factor 5	56, 1	60.06	2.43

* $p < .05$.
** $p < .01$.

The results in Table 25 suggest that individuals who have married again accept the loss of their previous spouses considerably better than those who are still widowed. However, individuals who have remarried also have a poorer feeling about their previous marriage with the deceased than those who have not remarried.

Age of survivor. The survivors responding in the present research were grouped into three age categories: those age 39 and below, those in their forties, and those 50 years and above. The results are indicated in Table 26. All five factors were non-significant.

TABLE 26

Analysis of Variance: Age of Surviors

Source	df	MS	F
Factor 1	2, 60	132.06	0.42
Factor 2	2, 60	32.15	0.64
Factor 3	2, 60	3.55	0.04
Factor 4	2, 60	27.33	1.33
Factor 5	2, 60	43.71	1.84

Education. The subjects responding to a or b (those without any college education) of the third demographic question were compared with those responding to c (some college education). The results are provided in Table 27.

Table 27 indicates that Factor 1 is significant both in comparison of the college-educated and non-college-educated, and in the AB comparison of suicide and non-suicide. A Newman-Kuels form of the Studentized range statistic was performed and it

TABLE 27

Analysis of Variance: Education

Source	df	MS	F
Factor 1 - A	1, 62	1473.48	5.32*
Factor 1 - AB	1, 62	1225.39	4.43*
Factor 2	1, 62	14.46	0.30
Factor 3	1, 62	167.90	2.05
Factor 4	1, 62	1.94	0.09
Factor 5	1, 62	20.05	0.81

* $p < .05$.

indicated that the college non-suicide mean was significantly higher than the other three means. This implies that the college-educated individual whose spouse dies by non-suicidal means does a significantly better job in accepting the loss than the other three groups.

Date of death. In the final analysis of variance, those responding whose spouses died in the first half of 1968 were compared with those whose spouses died in the second half of the year. The results are listed in Table 28.

TABLE 28

Analysis of Variance: Date of Death

Source	df	MS	F
Factor 1	1, 62	2276.70	8.10**
Factor 2	1, 62	68.47	1.47
Factor 3	1, 62	3.69	0.04
Factor 4	1, 62	3.94	0.19
Factor 5	1, 62	43.07	1.71

** $p < .01$.

Table 28 indicates that individuals whose spouses died in the second half of the year 1968 are still having more difficulty in emotionally accepting the loss (Factor 1) than those whose spouses died in the first half of the year.

T Test.

A t test of the five factors was performed on all the non-suicide groups comparing the subjects whose spouses died suddenly (i.e. within four days of the inception of the illness or accident) with those whose spouses' deaths were not sudden. The results are shown in Table 29.

TABLE 29

T test: Sudden and Non-Sudden Death

Source	df	t
Factor 1	29	1.11
Factor 2	29	0.56
Factor 3	29	0.71
Factor 4	29	0.48
Factor 5	29	0.23

Table 29 indicates that all five factors are nonsignificant since a t value of at least 2.05 is needed for significance.

SUMMARY

Chapter Five, besides pointing out several basic observations from the intensive interviews, also noted other statistical results concerning grief and suicide. Analyses of variance were performed and the positive results were as follows.

The individuals who attend organizations regularly are more religious and feel better about the marital relationship with the deceased than those who do not. Survivors (especially suicide survivors) who were married 10 years or less at the time of death are feeling less 'good' about the marital relationship at the time of

death than those who were married longer. The respondents with suicide ideation have a considerably more difficult time accepting the loss. They are also more lonely and lack meaning in life (Factor 5). The individuals with suicide ideation are less religious than those without suicide ideation. Roman Catholics feel more guilty about the death of their spouses and they also do not feel as good about the marriage relationship at the time of death. Those spouses who remarry, although not regarding their past marital relationship as highly as the widowed, are doing a better job presently in accepting the loss of their previous spouse. The college-educated non-suicide spouses accept the loss of the husband or wife better than the non-college-educated spouses, or the suicide spouses with some college education.

CHAPTER VI

DISCUSSION OF RESULTS FROM THE STANDPOINT OF THE MINISTER/COUNSELOR

In the present chapter the various results which were presented in Chapters Four and Five will be discussed more fully as to their value in aiding the minister/counselor in dealing with the survivors of a suicide. The purpose is not to develop an exhaustive picture of the suicide spouse's grief, since the research presented here is only exploratory. In the first portion of this chapter the importance of the study will be evaluated under the headings of religion and the church; suicide and its relationship to the grief response; and further aspects of grief responses. The second portion of the chapter will highlight a few suggested methods of therapeutic intervention.

I. THE IMPORTANCE OF THE RESEARCH

Religion and the Church.

The findings of the research presented in Chapters Four and Five evidence no significant differences between the religious aspects of the suicide and non-suicide spouse's grief response. The tendency (though not statistically significant) was for the suicide

spouses to feel they had been more religious since the death of their mates (in comparison to non-suicide spouses), but that the church had not been helpful to them in their grief. This tendency may be a reflection of the organized church's moral stance against suicide, and of the suicide spouses' feeling that they would not be as well accepted within it. No significant change of religious practices appeared in either group. Some individuals felt closer to God after their spouses' death and attended church more regularly. Others were angry at God for taking their spouses away. Still others who had gone to church in the past only because their husbands or wives had, now no longer attended. Only one of the 66 subjects had changed religious faiths from the firm conviction that another contained more truth.

The subjects who attended organizations regularly were more religious than those who did not, as might be expected. They also felt better now about their marriage with the deceased than did those who did not attend organizations regularly. A $\underline{X^2}$ test was performed comparing those who attended organizations regularly and those who did not, with the individuals who had or had not had counseling before the death. The latter variable was used since it was the best indicator in the grief inventory of previous emotional disturbance. The $\underline{X^2}$ after being corrected for continuity

equalled zero (see Appendix J for presentation of this $\underline{X^2}$). There was no significant difference between the individuals who attended organizations and those who did not in the amount of counseling before the death. This nonsignificant $\underline{X^2}$ tends to indicate that individuals who attend organizations regularly are feeling better about their marriage relationship with the deceased <u>because</u> of their participation in the organizations, and not because they were less disturbed prior to the death. (If the $\underline{X^2}$ had been significant, it could have been argued that the underlying variable was previous disturbance and those who attend organizations are less disturbed.) Although it cannot be stated conclusively that those who attend organizations feel better about their marriage with the deceased <u>because</u> they attend organizations, it appears to this observer that it is the case.

The negative results in the analysis of variance on church attendance reported in Chapter Five are quite interesting. They indicate that the regular church attenders do not have a better acceptance of the loss at a level of significance. Regular church attenders also do not have less guilt at a level of significance. There is no difference between the regular church attenders and the non-church attenders in their attitudes about the marriage relationship. These negative results make one wonder why the

churches are not meeting the needs of these individuals any more than they are. Is the church failing in this area? Is the church doing an adequate job of helping individuals come to grips with life and death, with grief and suffering? It appears that it is not.

However, even at the very worst, the church does not hurt the individual much. (The exception is in Factor 3 where church attenders tend to have less meaning and independent involvement in life and are more lonely than non-church attenders, though not at a level of significance.) On the other hand, regular church attenders tend to be less disturbed in their emotional acceptance of the loss and in the amount of guilt they feel. It needs to be reemphasized that the above results were not statistically significant. What the results indicate to this observer is that the church needs to come to terms more conclusively with death, life after death, and grief. These are central issues in religion and if they are neglected or inadequately handled, the church is failing its people.

It is interesting to note that in the analysis of variance comparing Protestants and Roman Catholics, the two factors on which Roman Catholics had significantly different scores were the two items which were <u>not</u> related to suicide (Roman Catholics had more guilt and a poorer feeling about the marriage relationship). Conversely, the two items which distinguish Roman Catholics and

Protestants were also the factors which differentiated the suicide and non-suicide spouses. One possible reason for the differences between Roman Catholics and Protestants could be that the Roman Catholics were from a lower socioeconomic group. To determine if such was the case, two $\underline{X^2}$ tests were performed comparing Protestants and Roman Catholics with first the two different educational levels, and secondly the income levels--the grief inventory's two best indicators of socioeconomic status. (See Appendix J.) The results of both tests were nonsignificant. Thus it can be said with some degree of certainty that there does not appear to be any appreciable difference in the socioeconomic status of the two groups, using the above two indicators.

It is the author's opinion that a good theory for why Roman Catholics have a poorer image of the marriage relationship is that because of their religious beliefs they tend to stick with their marriages longer than do the Protestants with more liberal ideas on divorce.

The reason Roman Catholics feel more guilty than Protestants about their deceased spouses may be related to the teachings of the Roman Catholic Church. It is hypothesized that Roman Catholics feel more guilty because their church puts more emphasis on sin, guilt, moral law, and authority.

A Newman-Kuels test of the four means indicated that the suicide-Roman Catholic mean on the guilt factor (22.5) was significantly lower than the other three means (30.5, 34.6, 37.3). This finding seems to suggest that the Roman Catholic Church's strong stand against suicide is causing spouses who have lost a husband or wife by suicide to feel considerably more guilty about it than all other spouses tested in the analysis of variance. This finding might prompt Roman Catholic theologians to consider the implications of their present stand on suicide as it affects the survivors of a suicide.

Probably the most important result of the factor analyses was that the questions related to suicide loaded in with the religion factor (Factor 3). This result may suggest that suicide is viewed by the general public as much more of a religious question than many men in the mental health professions consider it to be.

To further elaborate on this result, it is the author's observation that suicidologists do not view suicide as being as strongly laden with religious meaning in the eyes of the general populace as it appears from this study to be. Traditionally suicide was considered a strictly religious and moral question. The church throughout history has made pronouncements about suicide.[1] Recently, however, suicide has been studied more as a mental

health problem than a religious problem. The tendency has been for mental health professionals who are untrained in theology not to consider an individual's religious beliefs about suicide as being very important. It is believed by this author that the pendulum has swung too far in the opposite direction--from first dealing with suicide almost totally as a religious problem, to now treating it almost totally as a mental health problem and as a result neglecting the general public opinion that suicide is still a religious question.

If this analysis is correct, it is important for the pastoral counselor to use his unique training in theology and his unique role as a religious figure to aid suicide survivors in dealing with the guilt they feel. It is hypothesized that beneath the guilt of suicide survivors, in almost all if not all cases, is a feeling that one has somehow made a transgression against God, as well as against the deceased.

Thus it could be that suicide needs to be studied from a religious standpoint much more than it has been up until now, and it is hoped that more pastoral counselor-theologians will enter into the field of suicidology.

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[1]See Pretzel's dissertation for a history of the church's pronouncements on suicide.

The respondents in the present study are residents of one of the most urbane and secular cultures of our country, yet they indicate that the minister is a crucial figure during the first few days after a death. This is true for both regular and non-regular church attenders. Some of the respondents criticized the superficial or businesslike manner in which some ministers handled the funeral. It is hypothesized that ministers who have not come to terms with death and with the grieving process will tend to be emotionally distant at a time when the bereaved desire emotional closeness. "Speaking from the heart" in the funeral service was very important to some of the bereaved in this study. It seemed to symbolize genuine caring, both for them and for their deceased spouses. The funeral is the unique opportunity unavailable to others in the helping professions for the minister to aid the bereaved in their grief. It is a chance to proclaim the Christian hope, to comfort the bereaved, and to help the bereavement process.

The reaction to the whole funeral process varied from individual to individual. Only six of the total group who responded to the grief inventory's question on resources felt that the funeral was "very helpful" in their grief work; 60 individuals did not find it very helpful. This finding seems to point out the need for a total reevaluation of the funeral process, the funeral service, and the

cost of the funeral. If the funeral is not very helpful, or a hindrance to some people in their grief work, then the value of the high cost of death needs to be radically reconsidered. Is there not a more helpful form of "grief therapy" (to use the funeral industry's own term), dollar for dollar, than the funeral? It would be of little value simply to abolish funerals and the funeral service, but it would be valuable to lower the cost of funerals and make them more meaningful to one who is initiating a long period of grief. It is believed by this author that the financial burden the present funeral practice puts on some families outweighs any advantages the funeral might bring. It is also believed that other more generally helpful forms of grief therapy need to be developed.

Suicide and its Relationship to the Grief Response.

Three hypotheses have been developed as to why the subjects of the present study did not respond adequately to the suicide question on the grief inventory. The first hypothesis is that many individuals who are grieving are struggling with suicide ideation but will not admit it, and therefore did not respond. A second hypothesis, closely related to the first, is that the categories were not socially desirable (as most of the Likert-scale items were), and thus did not elicit much response. The third hypothesis is that the question itself was not well conceived or

easily understandable. It seems likely that all three of the above reasons are true, that all three causes influenced the low response rate on the suicide question. In looking over the inventories, one is struck by the number of respondents who filled in every other item except one or both portions of the suicide question. This low response may indicate that it is difficult to obtain accurate information concerning suicide ideation and behavior from the recently bereaved. Even with the low response rate it appears that the tendency is for suicide spouses to have more suicide ideation and activity. This is a fact that all who are doing pastoral counseling need to be aware of.

A striking finding was the significant difference between suicide and non-suicide spouses in the amount of sickness that they had experienced since the death. This finding suggests that the suicide spouses may be suppressing their mourning (especially their deep guilt and anger) and transferring it into physical symptoms, more than non-suicide spouses. Thus the present amount of physical illness (as compared to the amount before the death) is an important indication of a grief turned inward. It can be one of several indicators of how well an individual is responding to a death.

The analysis of variance which compared the suicide and non-suicide groups and the $\underline{X^2}$ of the Likert-scale questions on guilt indicates that suicide really works. That is, the individual who commits suicide is generally angry and disappointed in marriage, and suicide is often a way to retaliate at his spouse. Suicide is usually an angry, desperate gesture. Meerlo describes suicide as a type of mental blackmail in which the unconscious idea is to punish a disappointing individual.[2] Karon likewise believes that some forms of suicide are attempts to hurt someone else through the fantasy that killing oneself is an effective retaliation.[3] It appears, from the data in this study, that it does work. The suicidal death successfully makes the surviving spouse feel guilty. He feels angry with the deceased spouse, as well.

Because the type of factor analysis used was orthogonal and not oblique, Factors 2 and 4 cannot be considered to be highly related. This lack of relationship implies that the suicide spouse's poorer evaluation of the marriage relationship before death (Factor 4) is probably <u>not</u> due in any great extent to the

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[2]Joost Meerlo, <u>Suicide and Mass Suicide</u> (New York: Grune & Stratton, 1962).

[3]B. P. Karon, "Suicidal Tendency as the Wish to Hurt Someone Else and Resulting Treatment Techniques," <u>Journal of Individual Psychology</u> XX:2 (1964), 206-212.

greater amount of guilt he feels (Factor 2). Rather it is his present appraisal, after one to two years, of the quality of the marriage relationship he had the last few months before the death.

The stigma of suicide felt by the surviving spouses was tested indirectly by the question, "At times I have felt like I was being compelled to move residence because of what some people thought about my spouse dying." The reaction of three of the four suicide spouses who were interviewed was not to be very open with friends and associates about the fact that the type of death was suicide. Their secretiveness about the death, plus the suicide spouses' perception of blame from others, seems to add to the problem of the stigma of suicide. Instead of openly facing and dealing with the fact that one's spouse has died by suicide, most of the feelings about the suicide are held within. It is believed this compounds the grief reaction (i.e. it adds one extra aspect to work through), and it also can cause the spouse to perceive more stigma than might really exist. In other words, it is believed that if the suicide spouse openly faced the fact that the death was by suicide, and contended with this fact with his associates, then the perceived blame and stigma would not have such an effect on the spouse. One subject put it this way, "If I lied to them [to other people about her husband's suicide] I'd be lying to myself. . . .

You've got to face it. . . . and then they get to know later and they heard that he committed suicide and they want to know, Gee, I wonder why she's hiding it."

The analysis of variance comparing the respondents who had suicide ideation and behavior since the death (12 of the 53 individuals who responded to the question) with those who did not, is an important one even though the cells are quite unequal. It appears that suicide ideation and activity is one of the best indicators of a destructive grief reaction.

The minister/counselor who is concerned with controlling suicide ideation or behavior in a widowed client--no matter what caused the spouse's death--should not get bogged down by dealing with the individual's guilt. The reason for this is the fact that the amount of guilt the individual with suicidal ideation has is not significantly different from the amount of guilt in the person who does not have suicidal ideation or activity. Therefore, the guilt is not a major contributing factor to the suicide ideation. In such a crisis situation, it is important rather to focus on the person's emotional acceptance of the loss and also on the various aspects involved in Factor 5 (such as loneliness, lack of social involvement, etc.). The counselor also needs to deal with the individual's religious beliefs--helping the suicidal individual to develop meaning

in life, to express it in religious or quasi-religious beliefs, and to live by those beliefs.

Here again the pastoral counselor, with his unique training in theology, is better able to deal with the total character of the suicide survivor than is the non-theologically trained counselor. The minister is able to deal with questions of meaning and questions of religious belief, since this is his job. Frequently the non-theologically trained counselor will pass over the religious aspects of suicide, feeling he is not competent to handle it, and thus he misses one important resource which he could utilize in helping to mobilize the coping abilities of the suicide survivor. Jackson puts it this way:

> The pastor is not only a counselor with psychological understanding and a concern for the welfare of his parishioners' souls, but he is also the custodian of a philosophy of life and a concept of the universe that can replace despair with hope, fearfulness with faith, and guilt with feelings of forgiveness.[4]

It may be that previous research performed in the area of suicide, which has indicated that a suicidal death in the family is an important criterion for present suicide activity, has not been based completely on the right indicators. It is believed by the author that what is most important in an individual's present

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[5]Edgar N. Jackson, Understanding Grief (New York: Abingdon Press, 1957), p. 160.

suicide ideation is not the type of death (i.e. accident, suicide, homicide or illness), but rather whether or not the death is an upsetting one to the survivor. Research would be better not to simply question if the subjects have had a suicidal death in the family, but also to ask if they have had a particularly upsetting death in the family which they are still having trouble accepting emotionally. In other words, from the standpoint of how suicidal the survivor is at the present, the fact that the spouse committed suicide may be minor in comparison to the fact that it was a traumatic death which he is having trouble accepting. It must be granted, however, that suicidal deaths are generally more upsetting than non-suicidal deaths.

The analysis of variance on suicide activity indicates that religious beliefs tend to act as a partial immunization or protection from suicide ideation and behavior, and religion does have some effect in keeping grieving spouses from suicide activity. Individuals who exhibit suicide ideation and behavior are generally less religious. This may indicate that the Judeo-Christian concept of the value and meaning of life has an effect on its adherents. Those individuals who value religion and believe its tenents are less likely to be involved in suicide activity of any sort.

It is interesting to note that the guilt factor and the feeling about the marriage before the death do not necessarily relate to suicide ideation and behavior. In other words, the two factors which were statistically significant between suicide spouses and non-suicide spouses were not statistically significant when suicide ideation and the lack of it were compared. This fact is the basis for the above argumentation concerning previous research which has been done on suicide and the need for new research that would ask a subject if he had had a particularly upsetting death in his family that he was still having trouble accepting, rather than asking if he had had a suicidal death in the family.

Further Aspects of Grief Responses.

Finances. The majority of both groups (suicide and non-suicide) believed they had gotten along all right financially since the death of their spouses. A number of them indicated that it was "tight" financially but that they had managed to subsist.

Work. Work is very important to the grieving, both suicide and non-suicide. Fifty of the 57 individuals who had worked since the death noted that they had received a great deal of satisfaction from their work. Work helped them to keep busy instead of spending their time brooding. Several individuals

(especially men) expressed that they worked considerably more hours in a week than they had before the death. A few individuals even listed work as that which gave them meaning in life.

Resources. Forty-three of the 66 respondents felt that they themselves were very helpful in adjusting to their spouses' death. Besides themselves, the subjects' main resources were their children and their close friends. Next in order of priority were their relatives. Prayer and Bible reading were helpful to 18 of the 66 (27.3%). The minister and the church were valuable resources in the grief work of 14 and 12 respondents, respectively. Of the traditional medical and mental health professionals, only the family doctor seems to have been of much help. Counselors or psychotherapists, social workers, and other professionals account for helping only three people. This finding probably indicates two things: first, that individuals who are struggling with grief are not going to the traditional mental health professionals for assitance in their grief work; and secondly, that of the 14 subjects who were in counseling since their spouse died, only three felt they were helped very much in their grief work--11 didn't perceive themselves as being helped very much.

Thus, with the exception of the family doctor, the minister was the only professional important in aiding the grief sufferers in

this study with their grief. The church, reading of Scripture, and prayer were also very valuable to a number of the respondents. This author has observed that some ministers do not feel that religion, the preaching of the funeral sermon, and their pastoral counseling are very helpful to grief sufferers in our secular society. The data from this research indicates that their ministry can be very important in helping individuals deal with their grief. To quote Jackson,

> The minister, as the person designated by society to deal with the needs of the bereaved, should be aware of the importance of his function. It is not something to be treated casually or in a remote and formal manner. He has a chance to engage the personalities of the grief-striken in the constructive work of mourning, and he is guilty of professional negligence if he fails to do wisely and well what he is called upon to do.[6]

Length of grief period. The analysis of variance comparing the survivors whose spouses died in the first half of the year with those whose spouses died in the last half of 1968 indicated that with time, a person works through Factor 1 (the emotional acceptance of the loss), but that other factors do not change much with time. This lack of change in the guilt factor with time points out that the minister/counselor, if he wants to deal with the grief reaction of a

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[6]Ibid., p. 145.

suicide survivor who is not necessarily suicidal himself, needs to focus on the guilt the individual feels about the death. In other words, the emotional acceptance of the loss gradually increases with time. The guilt factor does not diminish to any significant degree in time and it is something the bereaved (especially the suicide survivor) continues to live with. Factor 5 also does not change with time. Therefore, general grief counseling needs to focus on Factors 2 and 5, and time will generally heal Factor 1 in a relatively normal grief.

The analysis of variance being discussed also points out another interesting fact, that the grief reaction is not nearly finished after a year's time (as some therapists have believed), but it continues for a long time after the death. If this were not so, Factor 1 in the present analysis of variance would not show a significant difference between the grief reactions of the individuals who had lost their spouses in the first and second halves of 1968.

Age of survivors. The analysis of variance performed on the age of the survivors was nonsignificant on all five factors. It points out that people in various stages of their middle years react much the same in their grief. Jackson maintains that adolescents act out their grief frequently as juvenile delinquents,

and that older individuals, while having less guilt that middle-aged people, manifest their grief by becoming ill more frequently.[7]

Length of marriage. The individuals in this study whose marriage to the deceased had been of the shortest duration did not feel as good about the marital relationship as those who had been married longer before the death. It is hypothesized that if individuals who had been married an average of two or three years were compared with the mean ages of 15.3 and 18.3 (the means of the suicide and non-suicide groups, respectively), more dramatic results would occur--particularly that the guilt factor would be significant. Further research will have to be focused on this hypothesis.

Remarriage. The subjects who remarried accepted the loss of their former spouses better than the individuals who were still widowed. The fact of remarriage implies either that those who marry again have done a good enough job in accepting the death of their former spouses so that they feel free to marry again, or that the process of marrying again and loving another person aids in the acceptance of the death of the previous spouse. It is the

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[7]Ibid., p. 42.

author's opinion that both of the above implications are true. In other words, an individual is more likely to consider loving another if he has severed his former relationship with the deceased. Also, the whole process of marrying again--of giving oneself again in love to someone else--is very helpful in accepting the loss of the deceased.

From a therapeutic standpoint, the above results suggest that it is advisable for a minister/counselor to be willing to accept or even motivate the bereaved spouse to remarry rather than to continue his at times rather idealistic image of the deceased and thus not completely accept the loss. The fact that the remarried have a less 'good' feeling about the previous spouse than the widowed may be because holding the deceased in esteem is not as essential to the survivors after they have remarried. They do not focus on their former relationship as much as they used to; it is not as important to them in comparison with their new, emerging relationship.

Educational level. The college-educated widowed individuals whose spouses die by non-suicide means do a better job in accepting the loss of the deceased. It is hypothesized that educated people have more resources to fall back on in times of crisis. They are better able to manipulate symbols within the

intellectual sphere; they are more aware of counseling opportunities; they are aware of more individuals they can talk to about their grief. However, to college-educated people who lose a spouse by suicide, the shock of this type of death seems much more devastating than with the less educated. A $\underline{X^2}$ test was performed comparing the college-educated with non-college-educated, and those who had had counseling with those who had not had counseling before the death. The results turned out to be nonsignificant. (See Appendix J.) If the $\underline{X^2}$ had been significant, it would probably have indicated that educated people were more stable and less disturbed, and non-educated people less stable and more disturbed, before the death. This was not so, however. Thus if one is college-educated and experiences the suicide of a loved one, he does not have the extra element of help in grief that other college-educated individuals have. Their acceptance of the loss then is like a non-college-educated person's. It shows that a suicidal death for this subgroup is more distressing than for the other subgroups.

II. THERAPEUTIC INTERVENTION

In the second part of Chapter Six, some rudimentary methods of therapeutic intervention for the minister or counselor

working with bereaved spouses will be suggested. Since the purpose of this dissertation was not to present a model of intervention with the bereaved but rather to describe for the minister or counselor the grief response of suicide spouses, the present section will be only a sketch of possible methods of helping the bereaved.

It should be noted from the very beginning that the pastor has several natural advantages in ministering to the bereaved that others in the helping professions do not have. In the first place, if the bereaved are members of his congregation, he already has a relationship with them. As a result he can move right into the situation without having first to develop rapport. Secondly, since the minister is the individual designated by society to deal with the deceased and with the survivors, he can involve himself and the church in the grief immediately after the death, and can usually keep in contact with the family long after the death. These unique advantages make the minister the ideal person to work therapeutically with the survivors of a death.

Considerations in Ministering to the Bereaved.

An important element which needs to be considered in ministering to the grieving is how old the grief is. A grief of only a few hours is handled somewhat differently from one six months old.

When the minister hears of the death, his first contact with the survivor is important. The bereaved needs someone who in a quiet, stable way lets him know he cares and is there to help in any way he can. The strength of the minister, as one who has lived through the griefs of many others, can be appropriated to some extent by the survivors. The minister should guide the survivor at this time, suggesting some alternatives of action which are open to him. He should avoid as much as possible making decisions for the survivor. Hopefully the family will have talked previously about what they will do when there is a death in the family, regarding the burial, funeral, care of children, finances, et cetera.

The minister/counselor must realize that the bereaved may be irritable or downright angry. He will be especially angry at those near to him at the time of the death. He will also frequently be angry at God and at God's representatives on earth --ministers. Therefore the minister may face a barrage of either subtle or overt anger in the first few days and frequently for many months following the death. It is important that he not be scared away by it. The minister wh o sees himself as a 'nice guy' may be offended and hurt by such outbursts of anger and may leave when the grieving person needs him most. This is most crucial in the

cases of suicide where the minister/counselor had been counseling the deceased before the suicide. The survivors may aim a lot of their anger at him and he must be prepared to handle it.

For the first few hours after the death until the funeral, the minister/counselor must be as accepting as he can, under the circumstances, of whatever the bereaved is feeling. He is to be a resource person for the bereaved, making suggestions and discussing alternatives for immediate action, without doing everything for the person. The minister needs also to respect the bereaved's wishes for quiet time alone to reflect on what has happened and to become more aware of his feelings. Sympathy is not helpful; it only makes the individual feel more depressed and helpless. On the contrary, gently prodding the survivor into action is frequently beneficial.

A week or two after the funeral, when most of the relatives have gone home, is a crucial time for the surviving spouse. Most of the spouse's friends and relatives are back to 'business as usual' and he is still very much feeling the loss of the deceased and the confusion about what to do next. At this time the minister/ counselor can express his concern (without sympathy) by helping the individual to begin to face reality and his present responsibilities. The minister/ counselor can aid him in solving his immediate and

short-range problems. Discussing alternatives (without making decisions) and gently nudging the spouse into action may be necessary. In the first few weeks what is most helpful for the bereaved is to be able to complete specific tasks successfully. If he tries to tackle too many or too difficult and complex tasks, and fails, he will feel even more helpless and depressed. These small early successes form a sound foundation upon which more difficult tasks can later be built.

It is a mistake for the minister/counselor to assume that, since the surviving spouse is functioning well in his home and work after three to six months, he is mainly over his grief. Because of the 'conspiracy of silence' in our society the survivors, although still feeling it, usually are not talking about their grief with others. Some of the survivors will not even be aware that what they are feeling is related to the death of the husband or wife some months ago.

Guilt.

If one major finding of this research were to be singled out, it would probably be that the main factor separating suicide spouses from non-suicide spouses is guilt. Traditionally the church and its ministers have been considered to have expertise in this area. It is the author's opinion that the church and the

pastoral counseling minister still have something very important to say to the issue of guilt.

Aden, in "Pastoral Counseling as Christian Perspective," maintains that what makes the pastoral counselor unique in his identity is that he works from " . . . a Christian perspective which seeks to help or to heal by attending to the life situation of the troubled person."[8] He maintains that this "Christian perspective" may not be very evident from a cursory examination of a minister's counseling techniques, but it is seen only at crucial points in his counseling. Aden identifies three marks of the Christian perspective--three problems which are pivotal in an individual's religious self-affirmation. They are (1) the problem of finitude; (2) the problem of alienation; and (3) the problem of guilt. He indicates that the problem of finitude is a grappling with the limitations of life; the problem of alienation with life's meaning; and the problem of guilt with fulfillment.[9]

The minister needs especially to help the suicide survivor deal with the third mark of the Christian perspective--guilt. This

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[8]LeRoy Aden, "Pastoral Counseling as Christian Perspective," The Dialogue Between Theology and Psychology, Peter Homans, editor (Chicago: University of Chicago Press, 1968), p. 167.

[9]Ibid., pp. 173-181.

guilt can come in many forms, some of which are disguised. It can appear as a sense of shame or failure, or of hopelessness and helplessness; it can be experienced as unworthiness, a sense of rebellion and disobedience, or as a feeling of pretense.

The Christian answer (using Tillich's method of correlation) to the guilt is forgiveness. To quote Aden,

> Forgiveness is the Christian's answer to man's struggle with guilt, not because it wipes away all guilt, but because it assures men of being "accepted in spite of his being unacceptable." Pastoral counseling, therefore, in attending to the client's struggle with guilt, seeks to help him move toward the existential and spiritual disposition of forgiveness or, more correctly, toward the acceptance of forgiveness.[10]

How can the pastoral counselor aid in the achievement of this forgiveness? He can use a number of methods which are valuable in dealing with guilt. These methods can also be of help in working with other phases of the grief reaction, but guilt is probably the most important aspect of the suicide grief reaction that the minister will have to deal with.

In the first place, just talking about the guilt, sharing and confessing it with another person, is helpful. It is even more helpful when the individual can share his guilt feelings in a group and still feel accepted by the group members. This indicates two

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[10] Ibid., p. 181.

very important points for the minister: (1) the necessity of acceptance; and (2) the value of confession. Let us look at both of these aspects more fully.

It is crucial in all counseling of guilt that the client feel he is accepted at a deep level, even though the counselor (and probably the client also) may not like what the client has done. Stein states, "The single most crucial factor in relating to the guilt-laden person is acceptance."[11] It is the counselor's acceptance of the client which in turn helps the client to accept himself more fully.

The confession of guilt is an established practice in the Christian church. Personal confession of guilt has fallen into disuse in many of the Protestant churches, especially in the more 'liberal' denominations. Confession, or acknowledgement of guilt, is a crucial aspect of pastoral counseling. The process of (1) confession or acknowledgement of one's guilt, (2) acceptance of forgiveness and absolution, (3) restitution for wrongs done when possible, and (4) amendment of life, is still a very viable process to occur in counseling.

The self-disclosure of the secrets that make one feel guilty

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[11]Edward V. Stein, Guilt: Theory and Therapy (Philadelphia: Westminster Press, 1968), p. 162.

is the first step in this method of dealing with guilt. Jackson comments, "When this activity is directed toward a creative newness of life, the tendency is to move away from morbid preoccupation with the past toward a healthy participation in the present and future."[12]

One problem the minister needs to be aware of, which Fromm, Parlour, Mowrer and others point out, is that the individual may plead guilty to lesser crimes and not tell his real guilt feelings. Sometimes a person feeling a lot of guilt will continually come to the minister, telling of one sin after another, most of which are fairly minor or superficial (Fromm calls this pseudoguilt). The alert minister needs to penetrate the facade of minor sins (whether they are related to the death or not), and get at the real feelings of guilt--these feelings may be that the person thinks he caused the death, or that he feels he is a failure as a person because of the marriage not going well and ending in suicide, et cetera. The job of the pastoral counselor here is to help the person confess what he is really feeling guilty about. Stein puts it this way:

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[12]Jackson, op cit., p. 128.

> The most important task of the pastoral counselor, perhaps of any counselor, is to help the counselee shift his concern from guilt feelings to what he genuinely is guilty of and to help the person explore and find ways of making value decisions about his life and acting on these. This means accepting responsibility for his life and authentically affirming it, moving toward self-actualization. This does not deny guilt, it accepts its reality, and redirects it toward channels that produce more lasting self-esteem and minimize not only the tendency toward, but the necessity for, self-punishment.[13]

The second aspect of this method of dealing with guilt, the acceptance of forgiveness and absolution, is difficult for anyone but a religiously oriented counselor to bring about in cases of guilt focused on what a person did toward the deceased or toward God. Jackson states, "When the person who could forgive is no longer present the effectiveness of an oversoul capable of forgiving is a source of release and comfort."[14] The minister as a representative of God can help the individual accept the forgiveness that is his from God. The minister has the advantage (especially in the more liturgical traditions) of being able to pray with the person for forgiveness of legitimate wrongs done to the deceased spouse, and of giving absolution. Prayer and absolution should not, however, be a way to shortcut the working through of the guilt.

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[13]Stein, op cit., p. 189.

[14]Jackson, op cit., p. 128.

Protestant churches, in their effort to affirm salvation as sola gratia and to separate themselves from alleged Roman Catholic "works righteousness" have deemphasized the importance of restitution and amendment of life. It is therapeutically valuable for the guilt-laden individual to attempt to make restitution for the wrongs he has done. The form that the restitution takes is completely open to the individual. Stein states, "It is possible for a person to eliminate a guilt feeling by going through an act of restitution--paying a price."[15] The minister needs to be careful that the guilt-laden individual does not construe that his worth and acceptance are based upon his doing the act of restitution. The client needs to be aware that he as a human being is already forgiven by God. Restitution is not a way of bribing God (or others) into accepting him.

The amendment of life is the final aspect in the process of dealing with guilt. Here the individual after evaluating his acts toward the deceased and his whole marriage relationship, makes a commitment to act differently, and then acts upon his commitment. This change of behavior can be very valuable from the standpoint of preventive pastoral counseling, because it can help the suicide

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[15]Stein, op cit., p. 164.

survivor change his way of acting so that he will not make many of the same mistakes in subsequent interpersonal relationships that he did in his relationship with the deceased.

The process of confession, acceptance of forgiveness and absolution, restitution, and amendment of life does not have to --and frequently will not--occur as a liturgical ritual. Frequently it will occur without the client's explicit awareness of what has happened. However, it is the belief of the author that the basic process of the forgiveness of guilt should be kept in mind while a minister is doing pastoral counseling, as a model of dealing with guilt in clients. There are several different ways in which guilt that seems blocked can be freed, so that the person can move toward forgiveness. The following paragraphs will suggest a few of the techniques other than the ones already mentioned.

Dorpat has indicated in personal conversations with this author that the guilt of suicide survivors frequently has a grandiose and irrational element to it. The belief is that if the survivor could have done 'such and such' then the individual would not have taken his life. (For example, "If I had just come home from work an hour earlier, I would have been able to save her," or "If I had just not argued back at him then he would not have been so angry and would not have killed himself.") Dorpat related that the method

he has found most helpful in such cases is "gently debunking" the grandiose assumptions of his client. He does this by gently and sometimes a little sarcastically confronting the client with reality --that he could not have really stopped the deceased spouse from committing suicide. He repeats this confrontation as often as necessary until change occurs.

A third technique of dealing with the guilt of a suicide spouse (and with other problems in a grief reaction) is chair dialoguing. There are two ways that chair dialoguing can be employed in dealing with guilt. The first method is to place an empty chair in front of the client and tell him, "This (pointing to the chair) is the feeling of guilt you have been talking about. I want you to give it a voice and let it speak to you." The second method (which generally seems more valuable to the author) is to tell the client that his deceased spouse is sitting in the empty chair, and to have the client talk to him or her. In both cases the individual is instructed to move back and forth between the two chairs and speak for both sides. If the client gets bogged down in the dialogue, the counselor can step into one of the parts and play it for a while, then step out when the dialogue is moving again. It is believed by the author that chair dialoguing may be one of the best techniques for helping individuals with their grief.

Another technique which, like chair dialoguing, is helpful for guilt as well as for other aspects of the grief reaction, is reviewing the client's life with the deceased, starting at an early time in the marriage and moving forward slowly toward the actual death and the events shortly thereafter. This technique can be used in several ways. First, the minister/counselor can simply ask the client to review his life with the deceased, and progress with the review to the last few days and the actual death, and finally to the client's image of the deceased. This review can be repeated several times until the anxiety and guilt about the death have decreased.

A second method of review is to use desensitization. The counselor and client compile a list of the events that preceded the death, listed in ascending order of anxiety and guilt, and proceed as with any other problem dealt with by desensitization.

A third way the review can be used somewhat combines the above two methods. The client is asked to sit in a relaxed position and close his eyes. The counselor then begins to review with the client his marriage relationship with the deceased, and the client visualizes (somewhat as in imaging) the events and describes and evaluates them with the counselor. From time to time the minister/counselor has the client open his eyes and

discuss what he has visualized. The process is continued until the client is visualizing the actual death scene and the deceased spouse, and can talk about it without too much trouble. When this review is complete, the client's guilt and anxiety should be reduced.

The above are a few of the ways which occur to the author as valuable methods of intervention into a survivor's guilt, especially with survivors who have deep and very disturbing guilt feelings. In discussing the role of the pastoral counselor in the guilt of grief, Jackson states,

> While it is accepted as an established fact that all grief involves some feeling of guilt and that it should be expressed creatively, it is important for the pastoral counselor to be aware of the situations of acute guilt that are precipitated by loss. It is here that deeper problems may reveal themselves. It is in this area that the alert pastoral counselor can assist in working through the guilt and freeing the personality from the deep and disturbing feelings that might cripple it for an indefinite period.[16]

The Stalemated Grief Reaction.

A final word needs to be said about how to deal with a stalemated grief. When a parishioner/client comes into counseling and appears to be fixated in one phase of his grief, two things must be done. First, the minister/counselor needs to find out where the

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[16]Jackson, op cit., p. 101.

individual's grief is stalemated (e.g. he is constantly irritable, or he has not yet allowed himself to feel the pain of grief, or he still is feeling a lot of guilt, etc.). The minister/counselor then needs to help the individual to get the grief process moving again. He does this by using any of the techniques discussed in this chapter to elicit and work through the unresolved part of the grief reaction.

The above has been a brief summary of some ways the minister/counselor can deal with grief. A full presentation of the methods of intervention would require a book, and are not within the confines of the present research.

CHAPTER VII

SUMMARY AND CONCLUSIONS

The final chapter of this dissertation will serve to tie together any 'loose ends' left by the previous chapters. In the first section the research project will be summarized. Secondly, suggestions for further research will be presented, and finally conclusions and suggestions which have arisen out of the presentation will be discussed.

I. SUMMARY

The research reported in this dissertation was designed to evaluate the grief response of middle-aged spouses whose mates committed suicide. Their grief responses were compared with the grief responses of non-suicide spouses.

Sixty-six individuals participated in the research (35 suicide and 31 non-suicide spouses). All subjects lost their mates in 1968 and were randomly sampled from Los Angeles County records.

A grief inventory was developed and pretested. The inventory was self-administered by the subjects at the end of 1969. The results were punched on computer cards and used for a

number of statistical tests. Chi square and t tests were performed on the 53 Likert-scale items and on the demographic data.

An orthogonal factor analysis was performed on the 53 Likert-scale items, and five factors resulted using 38 of the 53 items. The five factors are: (1) emotional acceptance of the loss; (2) guilt; (3) religious and belief system; (4) feelings about the marriage; and (5) meaning and independent involvement in life. Ten analyses of variance were performed on the five factors.

Intensive interviews were conducted with eight of the 66 respondents. The eight subjects were not selected randomly, but four subjects were chosen from each of the two groups (suicide and non-suicide), two male and two female in each group. They were chosen because of their willingness to be interviewed, and because of their varied response patterns as indicated on the grief inventory.

The basic hypothesis of this research was: The total pattern of the grief responses of suicide spouses will tend to be more disturbed than the grief responses of non-suicide spouses.

A series of predictions were formulated from the basic hypothesis. The predictions stated: (1) that the suicide spouses will not perceive the quality of the marriage relationship at the

time of death as being as 'good' as non-suicide spouses; (2) that the suicide spouse will not be as religious after the death and religion will not be as helpful to him; (3) that the emotional response to the death will be more disturbed in the suicide spouse; (4) that suicide spouses will not be as involved socially since the death and will not use as many resources; and (5) that the behavioral expresion of the grief process in suicide spouses will tend to be more disturbed than in non-suicide spouses.

The results of the research were discussed in two chapters. Chapter Four focused on findings related to the basic hypothesis. The statistically significant findings verified some but not all of the predictions formulated from the basic hypothesis.

One of the main findings of the study was the greater amount of guilt in suicide spouses than in non-suicide spouses. Associated with this guilt is a greater amount of anger directed toward the deceased spouse. Also, the suicide spouse senses the stigma of suicide and feels blamed to some extent for the death of his spouse. Another finding was that the suicide spouse does not feel as good about the quality of the marriage relationship at the time of death as does the non-suicide spouse. A final finding was that the suicide spouse is ill considerably more after the death of the husband or wife, in comparison with the non-suicide spouse.

Chapter Five indicated further results of the present research. It summarized some of the findings of the intensive interviews. It also presented the findings of those analyses of variance which did not deal with the basic hypothesis but were considered important for the research on grief. The findings were as follows. Subjects who attend organizations regularly are more religious and feel better about their marriage with the deceased. Those who were married 10 years or less at the time of death (especially the suicide group) do not feel as good about the relationship at the time of death as those who were married longer. The individuals who showed suicide ideation have a considerably more difficult time accepting the loss, and are more lonely and lack meaning in life; they are also less religious than those without suicide ideation. Roman Catholics feel more guilty about the death and have a poorer impression of the marriage relationship at the time of death than Protestants. The spouses who remarry do not regard their past marriage as highly as the widowed, but do a better job of accepting the loss of the previous spouse. The college-educated non-suicide spouses have an easier time accepting the loss of their mates than the spouses who had no college, or the college-educated suicide spouses.

Finally, the results presented in earlier chapters were discussed from the standpoint of the minister/counselor. Included were a few preliminary suggestions for counseling the bereaved.

II. SUGGESTIONS FOR FURTHER RESEARCH

An ideal study of grief, which the author would very much like to undertake in the future, would be a longitudinal study. Both written instruments and interviews would be used at specific intervals during a two-year period following a death. The intervals would be (1) the first day; (2) the day after the funeral; (3) two weeks after the death; (4) a month after; (5) three months; (6) six months; (7) one year; (8) one and one-half years; and (9) two years after the death. The aim would be to study the process of the grief reaction more intensely. The main problem involved in this type of research would be the bias incurred by the therapeutic questioning of the investigators.

Another research project to follow up the present one would delve more deeply into the guilt a suicide spouse feels. The aim would be a greater understanding of the guilt felt by the suicide spouse, so that the minister could more effectively help him.

Still another suggested area of research is to study more closely the suggestion arising from this study that the <u>type</u> of death

is not as important as whether the death is an upsetting one or not. Such research would compare individuals who feel they experienced a particularly upsetting death which they had trouble accepting, with those who experienced a more ordinary death. A study of this sort would lend more information concerning grief reactions which have turned morbid or pathological.

Still another research project could study suicide survivors of categories other than those studied in the present research, such as the child's reaction to a parent's suicide; the parent's reaction to a child's suicide; the reaction of a separated or divorced spouse to the suicide of his mate; the reaction of an elderly spouse to a suicide or the reaction of an early married spouse to a suicide; and so forth.

A final suggestion for a research project would be to study the effect of Parents Without Partners and other similar organizations on the grief reactions of widowed individuals who participate.

In general, it is the author's opinion that the whole field of grief is wide open to sound empirical study. It is hoped that further efforts will be spent in such research.

III. CONCLUSIONS AND SUGGESTIONS

In this final section of Chapter Seven a few deductions will be drawn from the findings of Chapter Four, Five and Six. A few suggestions arising from these deductions seem appropriate, though limited; therefore some proposals for ministers, full-time pastoral counselors, and mental health professionals will be set forth.

In the first place, there is a need for ministers and other individuals in the helping professions to become educated about the basic dynamics of grief, the special problems encountered in a suicidal death, and the special problems encountered in very upsetting deaths. Such education should not only focus on the theoretical aspects of grief, but should also involve the minister in reviewing his past griefs, and in sensing his own feelings about death. It also should involve ministers and others in working out their own theology (or philosophy) of death. Roman Catholic theologians in this regard need to evaluate their church's stance on suicide and their pastoral care of suicide survivors. There needs to be a change in the Roman Catholic Church so that the survivors do not carry an extra amount of guilt which appears to result from the church's teaching on suicide.

Secondly, there is a need to expose popular myths about death and grief. It was suggested earlier that Americans, while on one hand trying to avoid death completely, on the other hand have a fantasy about death which is as naive as the fantasy which many individuals carry into marriage. (Much of the present fantasy about death is perhaps formed by television and motion pictures.) Americans need to be reexposed to the reality of death and learn how to come to grips with it.

Ministers, lawyers and memorial societies should help people to plan in advance for death. Every married person needs to consider his own death and the death of his spouse, and they together should work out funeral and post-funeral arrangements in advance.

A fourth suggestion which has been alluded to previously is the need for people in suicidology to again view suicide as a religious phenomenon more than they have in the last decade. This is especially necessary in the therapeutic intervention with suicide survivors who (along with the rest of society) generally view the act of suicide as being contrary to religion. It is hoped that more pastoral counselor-theologians will enter the field of suicidology to give ministers and counselors a clearer picture of the full ramifications of how the belief that suicide is morally and

religiously wrong affects both those who are attempting suicide, and also the spouse of a completed suicide.

Fifthly, there is a need for more groups like Parents Without Partners, both within and outside of the church. The individuals in this study who attended such organizations felt they were very helpful in their grief. One individual noted the following on his questionnaire: "From my own experience I found that I recovered from the shock of death through my own efforts and joining Parents Without Partners. This group was a very big help as a crutch. When I found that I no longer needed a crutch, I withdrew from the organization and began life anew, with few regrets." Some churches have established groups such as Parents Without Partners. It was found from this study, however, that individuals who do not have children under 21 are frequently left out of such organizations, and that they also need to be included.

It would be valuable for churches to set up small groups of recently widowed spouses which could focus on helping each other to accept the loss of their loved ones.

The sixth suggestion is, in the author's opinion, a very important one. It concerns an individual's meaning in life. Although not a statistical finding, it is the impression of the author

that the individuals who have a broader and more firm meaning in life deal with their grief in a more constructive way. There appear to be two basic areas which give meaning to a person's life --principles and interpersonal involvement with significant individuals. Problems of meaning in life occurred with quite a few of the subjects in this study who responded that what gave them meaning in life was their involvement with their spouses or families, to the exclusion of other potentially meaningful aspects of life. Grief in such a case involves a substantial loss to one's meaning in life--which can lead to depression and suicide ideation and activity. If an individual focuses most of his meaning in life upon his children (as discussed in Chapter Four), he is in for trouble when his children begin to leave home. One interviewee who epitomized this problem said that all he had to live for was his boy, and his boy was soon to graduate from high school and leave home. This man said he now had nothing to live for and he wished he could die.

The problems resulting from too narrow a focus of one's meaning in life points to the need for developing interpersonal relations in depth with individuals beyond the small family group. It is dangerous to invest oneself in just one other person. Further indicated is one of the basic needs of our time--for people to live

principled lives, to develop beliefs and then live by them. In both of these aspects of meaning in life, the church and its ministers need to become more involved.

Another way the church might help the bereaved is to establish a lay task force group on grief "to surround the bereaved persons with Christian concern," as one Minneapolis church has done.[1] The purpose of this task force would be for several of the members to establish an ongoing relationship with each bereaved family in the church through frequent visits during the more neglected period of the grief (two weeks and hence after the death). Here is an opportunity for laymen to express their Christian concern concretely, and at the same time greatly aid the grief of someone within the community.

Finally there is the need, as suggested earlier, for a radical reevaluation of the whole funeral process. Funeral services and practices need to be developed which really aid the bereaved in their grief. Funeral costs should be lowered so as not to be a hardship on the survivors. More valuable and need-satisfying methods of grief therapy beside the funeral can be

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[1]Irene E. Clepper, quoted by Howard J. Clinebell, Jr., Basic Types of Pastoral Counseling (New York: Abingdon Press, 1966), p. 187.

developed. One possibility would be for funeral establishments to hire pastoral counselors to do follow-up work with the bereaved for a two-year period following the death. Another possibility was suggested by the results of the intensive interviews. A few interviewees indicated that they felt better about the death of their spouse after talking frankly about it. Several said it was the first time they had ever really talked in depth about their loss. It could be that the minister/counselor should have as part of his task periodic talks with recent survivors. These talks would serve as primary preventive counseling whereby any blocked aspects of the individual's grief could be dealt with, and they could help to prevent what Lindemann calls 'morbid' grief reactions.

It might also be helpful for the coroner's office to hire mental health professionals, or for the Suicide Prevention Center to have as part of its services a team of individuals who would go immediately to the home of the suicide survivors and aid them in their special grief. The ministers or counselor who does this would then continue to visit the survivor periodically over a two-year period or until he has made a good adjustment to his loss.

All of the suggestions mentioned above could help the survivor of a suicide to cope better with the stigma, the guilt, the

anger, the feelings of isolation that they sense. It would be the hope of the author that some of these methods can be instigated in an effort to ease the pain of such an individual, and perhaps even prevent another suicide.

APPENDICES

APPENDIX A

SUBJECT SAMPLE

Sample and Response by Months

Month	Suicide		Non-Suicide	
	Sample	Response	Sample	Response
Jan	6	3	5	4
Feb	6	1	10	5
Mar	10	7	6	3
Apr	7	6	6	3
May	4	3	4	2
June	7	5	8	3
July	3	2	4	2
Aug	4	2	7	6
Sept	5	1	1	0
Oct	1	1	2	1
Nov	4	2	4	1
Dec	3	2	3	1
Total	60	35	60	31

Total Sample by Six Months

	Suicide	Non-Suicide
January - June	25	20
July - December	10	11

APPENDIX B

THE GRIEF INVENTORY DATE: _____

DIRECTIONS: Please answer all of the following questions. Please do not leave any blank spaces. There are no right or wrong answers. Please answer each question honestly as to how you feel --not what others think. All of your answers will be kept absolutely confidential.

It is realized that some of the questions touch deep emotions and may be hard to answer. The effort you put into answering these sometimes difficult questions is much appreciated.

NOTE: "Spouse" means your husband or wife who died in 1968.

I. BASIC INFORMATION

1. Your age: _____

2. Present marital status, since death of spouse in 1968: (circle one)
   a. Engaged
   b. Re-married
   c. Re-married & separated
   d. Re-married & divorced
   e. Widowed

3. Your education: (circle one)
   a. Up to 8th grade
   b. 8th to 12th grade
   c. Some college

4. Type of present employment: _____

5. How long had you been married at the time of death?
   _____YEARS

6. Have you moved since your spouse died?
   a. No
   b. Yes
   c. Moved more than once

7. Cause of spouse's death:
   a. Accident
   b. Illness (How long ill _____)
   c. Suicide

8. In each of the parentheses below write the number of different organizations and clubs (church, political, social, fraternal, etc.) you:
   a. Belong to ( )
   b. Attend regularly ( )
   c. Contribute financially to ( )
   d. Belong to committee within the organization ( )
   e. Hold an office in ( )

9. Annual income:
   a. to $2999
   b. $3000-5999
   c. $6000-8999
   d. $9000-11,999
   e. $12,000-14,999
   f. $15,000 plus

10. Religious affiliation:
   a. Protestant
   b. Roman Catholic
   c. Orthodox Church
   d. Jewish
   e. Other
   f. None

11. Have you taken on any new religious practices or joined a different church or denomination since your spouse's death? (i.e., spiritual seances, joined new church, etc.)
   a. No
   b. Yes (If yes, please write on the reverse side of this page what led to the change.)

12. How often do you attend church?
   a. Just about every week
   b. Once a month or more
   c. Several times a year
   d. Never

13. Please write on these lines what a rabbi/minister/priest did that aided you in your time of grief. Please also write what he did that was <u>not</u> helpful. (Use back of this page if you need more space.)

_____

_____

_____

_____

_____

II. Please answer the following questions honestly, stating how you have felt <u>since</u> the death of your spouse. Read each statement and decide how much you agree or disagree with it. Then circle the number that corresponds to your feelings.

	Agree very much	Agree pretty much	Agree a little	Disagree a little	Disagree pretty much	Disagree very much
I have not been as healthy since the death of my spouse (i.e. asthma, rheumatism, colds, rashes, headaches, etc.)	1	2	3	4	5	6
I have gotten along all right financially since the death of my spouse.	1	2	3	4	5	6
I believe I have been more religious since the death of my spouse.	1	2	3	4	5	6
My church has not been of very much help to me in the hard times since my husband/wife died. . . .	1	2	3	4	5	6

Our marriage at the time of death was going "downhill." 1 2 3 4 5 6

I feel the funeral helped me greatly at the time of his/her death. 1 2 3 4 5 6
(Please write on the back what in the funeral helped you and what did not.)

At times I have felt like I was being compelled to move residence because of what some people thought about my spouse dying. 1 2 3 4 5 6

I have felt like I (and/or some of my children) have needed counseling since the death of my spouse. 1 2 3 4 5 6

Have you had counseling? (Yes____ No____)
From whom (social worker, psychologist, minister, etc.) _____
Had you ever had counseling before your spouse died? (Yes____ No____)

My children have been more difficult to raise since my spouse's death. 1 2 3 4 5 6
If no children living with you at time of death, check here ( ).

Friends and relatives don't seem as close to me as they did before my spouse died. 1 2 3 4 5 6

The death of my spouse has made me turn to God for help. 1 2 3 4 5 6

I don't completely understand why, but in the last few months before the death of my spouse, we argued and verbally fought a lot. 1 2 3 4 5 6

Since my spouse died I have not had anything to live for. 1 2 3 4 5 6
(If you disagree, who or what gives you meaning in life? _____)

I now feel left out of social life more than I used to be. 1 2 3 4 5 6

My spouse hardly ever confided in me. 1 2 3 4 5 6

I have felt blamed by others to some extent for my spouse's death. 1 2 3 4 5 6

I am drinking more alcoholic beverages than before the death. 1 2 3 4 5 6
(Check here if you have never drunk. ____)

There have been times since he/she died that I have felt mildly irritated or disappointed in him/her. 1 2 3 4 5 6

Since my spouse died I get annoyed or irritated more easily than I used to. 1 2 3 4 5 6

I am a more lonely person since the death of my spouse. 1 2 3 4 5 6

Since the death of my spouse I have been using more drugs (such as tranquilizers, sleeping pills, narcotics, pep pills, etc.). 1 2 3 4 5 6

I am not as confident about the future as I was before the death of my spouse. 1 2 3 4 5 6

I have not cried to speak of since my spouse died. 1 2 3 4 5 6

Circle any of the following which were very helpful in aiding you to adjust to your spouse's death.

a. Yourself
b. A minister/rabbi/priest
c. Your parental family
d. Other relatives
e. Your children
f. Counselor/psychotherapist
g. Friends
h. Prayer and reading the Bible
i. Church
j. Your family doctor
k. Social worker
l. Other professionals
m. Funeral
n. No one
o. Other _____

III. Please answer the following questions as to how you feel <u>now</u>. Read each statement and decide how much you agree or disagree.

	Agree very much	Agree pretty much	Agree a little	Disagree a little	Disagree pretty much	Disagree very much
I feel independent now, not needing to depend on others.	1	2	3	4	5	6
I can take religion or leave it.	1	2	3	4	5	6
Prayer can solve many problems.	1	2	3	4	5	6
Once in a while I put off to tomorrow what I ought to do today.	1	2	3	4	5	6
God protects from harm all those who really trust in him.	1	2	3	4	5	6
Nothing is worth killing yourself for.	1	2	3	4	5	6
It does not take me long to get over feeling gloomy.	1	2	3	4	5	6
I am looked upon as being of small or no account in other people's eyes.	1	2	3	4	5	6
Sometimes when I am not feeling well I am cross.	1	2	3	4	5	6
I feel trapped, oppressed, forced to do things I don't want to do.	1	2	3	4	5	6
I get a great deal of satisfaction out of my work. (Check here if you have not worked full or part time since your spouse died. _____)	1	2	3	4	5	6
I feel pretty generally secure and free from care.	1	2	3	4	5	6
Suicide is morally wrong.	1	2	3	4	5	6

I still have trouble realizing that my spouse is dead. 1 2 3 4 5 6

I refuse to allow myself the slightest self-indulgence or impulsive action. 1 2 3 4 5 6

I have some trouble sleeping and wake up more tired in the morning than I used to. 1 2 3 4 5 6

I feel physically tired much of the time. 1 2 3 4 5 6

At times I feel I deserve to be punished. 1 2 3 4 5 6

I feel depressed and very low and miserable most of the time. 1 2 3 4 5 6

After a while I got tired of people always trying to console me about my spouse's death. . . 1 2 3 4 5 6

I feel guilty about some things I said and did before my spouse died. 1 2 3 4 5 6

I fear to express my deepest feelings to other people, even those close to me. 1 2 3 4 5 6

I often think I should have done more for my spouse before he/she died. 1 2 3 4 5 6

Although I feel I maybe shouldn't, at times I feel ashamed about the way my husband/wife died. . . 1 2 3 4 5 6

If it weren't for my spouse, I'd be in a lot better shape today in this world. 1 2 3 4 5 6

I just can't seem to get over the death of my spouse. 1 2 3 4 5 6

Although I don't like to think of it, I feel at times as if I were part of the cause of my spouse's death. 1 2 3 4 5 6

I am distressed by my weakness and lack of ability, sick of my incompetence. 1 2 3 4 5 6

I do not like everyone I know. 1 2 3 4 5 6

I try to avoid anything that reminds me of my spouse. 1 2 3 4 5 6

Would you be willing to talk further with Mr. Stone about the death of your spouse if you were chosen to do so? Yes_____ No_____

IV. Are there any other things that you could add that would clarify any of the questions or that you would like to add? (Use back of this page if you need more space.)

APPENDIX C

LETTER OF INTRODUCTION

School of Theology at Claremont
1325 North College Avenue
Claremont, California 91711

Dear Friend:

Last year you were saddened by the death of your spouse. Death is not usually an easy thing to adjust to--especially when it is your own husband or wife.

For some reason, probably because people do not like to think or talk about it very much, the response of the family to the death of a husband or wife has not been adequately studied. In preparation for my doctor's degree at the School of Theology, I am working with my advisor, Dr. Howard Clinebell, in attempting to learn more about this.

Your name has been selected from the Los Angeles County's public files of death certificates to participate in a study of how people felt about losing their spouse, and how they are getting along now. Your assistance in this work may lead to a greater understanding of the problems of widowed people, so some steps can be taken to begin to solve them. You can help in this venture by filling out the "Grief Inventory" with any comments you may wish to add about how you feel about the Inventory, or your feelings about living without your deceased husband or wife. Your cooperation is very much needed so that other people in the future may be better helped in their time of bereavement.

Your answers will be totally confidential. You do not need to sign the questionnaire--your answers will only be associated with the number on the top of the inventory. All that will be known is that you are one of a selected group of people whose spouses died in 1968.

The volunteer who is helping me in this research will try to answer any question you have either before or after filling out the inventory.

Your token honorarium of $5.00 for participating in this research, along with my hearty thanks, will be in the mail within two weeks after I receive the questionnaire back.

If you have any questions at all, please call me collect at the School of Theology, preferably in the evenings. My number is (714) 621-2053. Again, thank you for your participation.

Sincerely yours,

Howard W. Stone

HWS/ks

FOLLOW-UP LETTER USED WHEN A PERSON

COULD NOT BE CONTACTED BY PHONE

School of Theology at Claremont
1325 North College Avenue
Claremont, California 91711
December 31, 1969

Dear Friend:

You may have received this questionnaire a couple of weeks ago (before Christmas) and have not been able to complete it. At least we do not have a record of a returned questionnaire from you. If you have mailed it already, please disregard this request.

Let me again explain the research that is being done. Your name has been selected from the Los Angeles County's public files of death certificates to participate in a study of how people felt about losing their spouses, and how they are getting along now. Your assistance in this work may lead to a greater understanding of the problems of widowed people, so some steps can be taken to solve them. You can help in this venture by filling out the "Grief Inventory" adding any comments you may wish concerning how you feel about the Inventory, or your feelings about living without your deceased husband or wife. Please return the questionnaire in the enclosed envelope as soon as possible. Your cooperation is very much needed so that other people in the future may be better helped in their time of bereavement.

Your answers will be totally confidential. You do not need to sign the questionnaire, and your answers will only be associated with the number on top of the inventory, which is used by the computer. All that will be known is that you are one of a selected group of people whose spouses died in 1968.

To express our appreciation for your help in this research, a $5.00 token honorarium will be in the mail to you immediately after I receive the questionnaire back, along with my hearty thanks.

We feel this is very important research, and we need your participation. If you have any questions about the research or problems in

filling out the questionnaire, please feel free to call me collect at the School of Theology, preferably in the evening. My number is (714) 621-2053. Again, thank you for your participation.

Sincerely yours,

Howard W. Stone

HWS/ks
Enc.

APPENDIX D

INFORMATION SHEET GIVEN TO VOLUNTEERS

DELIVERING THE QUESTIONNAIRE

VISITORS INFORMATION

For some reason, probably because people do not like to think or talk about it very much, the response of the family to the death of a husband or wife has not been adequately studied. In preparation for my doctor's degree at the School of Theology, I am working with my advisor, Dr. Howard Clinebell, in attempting to learn more about this.

To get a clearer understanding of the way spouses react to their husband's or wife's death and to widowhood, the "Grief Inventory" has been carefully developed. Its purpose is to see more clearly how a husband or wife whose spouse died by accident, suicide or illness will reorganize their lives without the deceased. The answers from the inventories will be put on IBM cards and run through a computer. The results will aid me in more accurately understanding grief so that ministers and others in the helping professions will be able to minister to these people in a way that will meet their needs. This is my hope, at any rate. The inventory will not be the only part of this research project, but will lay a groundwork for some later in-depth interviews which I will make with some of the people you will be visiting.

There will be 60-80 people throughout Los Angeles County who will be contacted by volunteer visitors like you. I have selected their names from L. A. County's public files of death certificates for the year 1968. Their answers to the questions will be kept absolutely confidential. They will be known only by the code number assigned to them and written on the top of the first page of this "Grief Inventory."

It would probably be good for you to know the definitions of two crucial words as they are used in the inventory: (1) Spouse refers to the husband or wife of the person being tested. He (or she) was living with the deceased at the time of death in 1968. (2) Grief

refers to the emotional response of a mourning person to the loss of a loved one by death. It is the way the survivors re-orient their lives emotionally without the deceased.

Here is what you do:

1. I will call the survivor who is being tested and arrange for a time for someone to go over to their house.

2. I will call you or the person who is in charge of visitors in your area and give you the name and address and the code number of the person to be visited, as well as the time of the visit. Mark the code number down on the back of the envelope and on the top of the first page of the inventory.

3. You go to the house promptly at the appointed time and introduce yourself, and give them the introductory letter.

4. When you are inside, you give them the inventory and briefly answer any questions they have. Try not to say too much to them until they have completed the inventory. If you don't know the answer to a question, tell them frankly and let them know that they can call me if they wish. Tell them to take their time in filling out the inventory and that you will wait until they are done. It would be good for you to bring along a book or magazine to read while they are taking the test.

   If they say that they can't fill it out at that time (even though they have already said they would), then ask if you can come back at another time. If that can't be worked out, ask if you can leave the inventory with them and they can mail it to me in the envelope that is provided.

5. Help them with the meaning of any word they don't understand (such as grief, spouse, mourning, etc.).

6. Have them check over the inventory to see if they have filled in everything, especially the blank lines on page 2.

7. At this point it is up to your discretion to decide if they want to talk to you about any of the feelings that the inventory will inevitably bring up. If either you or they do not seem to want to talk, then thank them and tell them that their "token honorarium" will be in the mail in about two weeks. Fold up the

inventory and place it in the envelope in front of them. Seal the envelope.

8. Bring the envelope back to the person who is in charge of them in your area, at your earliest convenience.

Keep track of your gas and oil expenses, and also any meals you eat away from home as a result of the volunteer work.

I very much appreciate your cooperation in this research. I have really been happy with the way many of you have responded so graciously and willingly to lessen the load of this research. It is my hope that from the effort of you volunteers, myself, and those taking the inventory, some good will come, and widowed people will be better understood and cared for by others.

APPENDIX E

SCHEDULE FOR INTENSIVE INTERVIEWS

INTRODUCTION

1. Tape recorder--so I don't have to write--for my personal use only!
2. Anonymous and confidential nature
3. Purpose
   a. Better understanding of grief, or your particular way of coping with it.
   b. The purpose of this research is to understand how people deal with the grief over a husband's or wife's death. In so doing it is my hope that those people who have a hard time in grief--just can't seem to get over it--can be helped.
   c. Questionnaire forces you to answer in specific ways; here it is open-ended. I have some general questions written down here to aid our discussion, but you feel free to add anything you want.
   d. It is also hoped that it may be helpful to you, discussing the loss of your husband/wife today, that together we may get a realistic picture of what has happened.
   e. Don't be afraid of offending or shocking me with any feelings you may have that seem unacceptable. I think I can accept what you have to say.

I. PRESENT SITUATION

1. Husband/wife died when in 1968?
2. Working now? Since the death? How has it been financially?

II. DEVELOPMENTAL HISTORY

1. Parents living? Relationship with each parent, in a couple of words.
2. Are parents dead; how differently did you react to their deaths as compared to husband/wife.

III. BACKGROUND LEADING TO SPOUSE'S DEATH

1. How had the marriage with the spouse been the whole time; how was it the last year or two before the death. Were you close to each other?
2. What were the events leading to your spouse's death (accident, suicide or illness).
3. What was his death like.
   a. What were your first responses; how did you feel.
   b. How long did first feeling last.
   c. When did you start coming out of the cloud and begin again a normal life.
   d. How did friends and relatives, business associates, react to the death? What is their reaction now to it?
   e. Have you ever felt like you were going insane or were going to have a nervous breakdown since the loss? Before?
   f. Have you ever thought of suicide? What's happened?
   g. Feeling about the suicide. Blamed by others? Compelled to move?

IV. THE FUNERAL

1. Helpful or not--feeling about it--expensive, easy to arrange? (Have trouble arranging funeral or getting a minister because spouse died by suicide?)
2. What was most and least meaningful in it--what would you do differently.
3. How did people act towards you at the funeral and the first few weeks after the funeral.

V. THE GRIEF REACTION

1. Feelings of irritation or anger at spouse--feel guilty about it?
2. Who did you tell feelings to when going through first weeks of grief reaction?
3. Depression?
4. Guilt--sorry about somethings?
   a. Feel like you could have done more to help him/her?
   b. Thought that you could have prevented his death?
5. Suicidal feelings?
6. Become nervous, or had periods of nervousness?
7. Dreams and fantasies--still have them--describe a

dream. (Ask for their understanding of the dream.)

8. Any strange things happen to you? (Such as spiritual things--feeling the deceased's presence?)
9. Do people still talk about your spouse to you or avoid it?
10. How did children react? How has raising them been since your spouse is gone?
11. What were the crucial periods of adjustment?
12. What has been most helpful in adjusting to living without spouse--what has not worked? What would you do differently?
13. Are you as involved in as many social activities as before? Made new friends?
14. Are you as close to your friends and relatives as before?
15. Remarriage.
16. How does it feel to be both mother and father.

VI. RELIGION

1. What gives you meaning in life?
2. Did a minister visit you within a few weeks afterwards? What happened? Does he talk to you about your spouse any more?
3. Did he do burial sermon? (Reactions.)
4. Any changes in religious practices or beliefs?
5. Involvement in church--change?
6. Belief in God--change?
7. How important is religion in your life--change?
8. How do you view other people's attitude toward you? Is life cruel, happy? How does life look to you now--change?
9. How has your caring for others changed?
10. Belief in life after death--how firm.

VII. FEELING ABOUT DEATH

1. How do you feel about death now? Life? Has it changed?
2. How do you feel about your dying and your death.

VIII. PRESENT

1. How do you feel about yourself now.
2. Making plans for future--does future look good or bad.

IX. SPECIFIC QUESTIONS DEVELOPED FROM THE INDIVIDUAL'S QUESTIONNAIRE

SUMMARY

1. Anything to add?
2. How do you feel about the interview?

APPENDIX F

THE FIVE FACTORS

FACTOR I. EMOTIONAL ACCEPTANCE OF THE LOSS

(EXCEPT GUILT)

Acceptance of the loss.

I still have trouble realizing that my spouse is dead.

I just can't seem to get over the death of my spouse.

Physical reaction to the grief.

I have not been as healthy since the death of my spouse (i.e., asthma, rheumatism, colds, rashes, headaches, etc.).

I feel physically tired much of the time.

Since the death of my spouse I have been using more drugs (such as tranquilizers, sleeping pills, narcotics, pep pills, etc.).

I have some trouble sleeping and wake up more tired in the morning than I used to.

Need for counseling.

I have felt like I (and/or some of my children) have needed counseling since the death of my spouse.

Anger (irritation).

Since my spouse died I get annoyed or irritated more easily than I used to.

Anxiety.

I feel pretty generally secure and free from care. (Negative loading)

Depression.

It does not take me long to get over feeling gloomy. (Negative loading)

I feel depressed and very low and miserable most of the time.

Feeling trapped; lack of confidence in self and future.

I am not as confident about the future as I was before the death of my spouse.

I am distressed by my weakness and lack of ability, sick of my incompetence.

I feel trapped, oppressed, forced to do things I don't want to do.

Crying.

I have not cried to speak of since my spouse died. (Negative loading)

FACTOR II. GUILT

Guilt.

I feel guilty about some things I said and did before my spouse died.

I often think I should have done more for my spouse before he/she died.

Although I feel I maybe shouldn't, at times I feel ashamed about the way my husband/wife died.

Although I don't like to think of it, I feel at times as if I were part of the cause of my spouse's death.

Perceived blame.

I have felt blamed by others to some extent for my spouse's death.

Perceived social respect.

I am looked upon as being of small or no account in other people's eyes.

Anger (irritation) at spouse.

There have been times since he/she died that I have felt mildly irritated or disappointed in him/her.

FACTOR III. RELIGIOUS AND BELIEF SYSTEM

Religiousness of respondent.

I can take religion or leave it. (Negative loading)

I believe I have been more religious since the death of my spouse.

The death of my spouse has made me turn to God for help.

God protects from harm all those who really trust in him.

___ Prayer can solve many problems.

Beliefs on suicide (religious and otherwise).

Nothing is worth killing yourself for.

Suicide is morally wrong.

FACTOR IV. FEELING ABOUT THE MARRIAGE

Our marriage at the time of death was going "downhill."

I don't completely understand why, but in the last few months before the death of my spouse, we argued and verbally fought a lot.

My spouse hardly ever confided in me.

If it weren't for my spouse, I'd be in a lot better shape today in this world.

FACTOR V. MEANING AND INDEPENDENT INVOLVEMENT IN LIFE

Since my spouse died I have not had anything to live for.

I am a more lonely person since the death of my spouse.

I now feel left out of social life more than I used to be.

I feel independent now, not needing to depend on others. (Negative)

At times I feel I deserve to be punished.

APPENDIX G

DEMOGRAPHIC DATA

I. BASIC INFORMATION

1. Age:

	Suicide	Non-Suicide	Total
25 - 29		1	1
30 - 34	2	3	5
35 - 39	9	4	13
40 - 44	7	6	13
45 - 49	10	11	21
50 - 54	3	3	6
55 - 59	3	1	4
60 - 64	1	2	3
Total	35	31	66

High age:
- Suicide: 62
- Non-suicide: 66

Low age:
- Suicide: 31
- Non-suicide: 27

Means:

Suicide male:	46.5	Non-suicide male:	48.1
Suicide female:	42.4	Non-suicide female:	40.8
Total:	44.3	Total:	44.3

2. Present marital status since death of spouse in 1968:

	Suicide	Non-Suicide	Total
Engaged	2	1	3
Re-married	7	7	14
Re-married & separated	1	1	2
Re-married & divorced		1	1
Widowed	25	21	46

3. Education:

	Suicide	Non-Suicide	Total
Up to 8th grade		1	1
8th to 12th grade	16	14	30
Some college	19	16	35

4. Type of present employment - - - - - - - - - - - - - - - - -

5. How long had you been married at the time of death?

	Suicide	Non-Suicide	Total
0 - 5 years	8	3	11
6 - 10 years	4	3	7
11 - 15 years	5	4	9
16 - 20 years	5	6	11
21 - 25 years	9	12	21
26 - 30 years	4	3	7

Means:

Suicide male:	16.0	Non-suicide male:	19.6
Suicide female:	14.7	Non-suicide female:	17.1
Total:	15.3	Total:	18.3

6. Have you moved since your spouse died?

	Suicide	Non-Suicide	Total
Yes	11	10	21
No	24	21	45

7. Cause of spouse's death:

Accident: 3
Illness: 28
Suicide: 35

Sudden deaths: 11 (non-suicide)
Non-sudden deaths: 20 (non-suicide)

8. Organizations and clubs:

	Suicide	Non-Suicide	Total
Belong to	20	18	38
Attend regularly	8	13	21
Contribute financially	18	17	35
Belong to committee	2	5	7
Hold an office		2	2

9. Annual income:

	Suicide	Non-Suicide	Total
to $2999	2	3	5
$3000 - 5999	8	8	16
$6000 - 8999	4	4	8
$9000 - 11,999	4	7	11
$12,000 - 14,999	6	3	9
$15,000 plus	9	4	13
No answer	2	2	4

10. Religious affiliation:

	Suicide	Non-Suicide	Total
Protestant	20	18	38
Roman Catholic	6	7	13
Orthodox Church			
Jewish	6	1	7
Other		1	1
None	3	4	7

11. New religious practices:

	Suicide	Non-Suicide	Total
Yes	2	3	5
No	33	28	61

12. How often do you attend Church:

	Suicide	Non-Suicide	Total
Just about every week	5	5	10
Once a month or more	4	4	8
Several times a year	15	15	30
Never	11	7	18

13. Write what a rabbi/minister/priest did that aided you in your time of grief. -

APPENDIX H

LIKERT-SCALE ITEMS

II. Please answer the following questions honestly, stating how you have felt since the death of your spouse.

	S or N	1 Agree very much	2 Agree pretty much	3 Agree a little	4 Disagree very much	5 Disagree pretty much	6 Disagree a little	N	✓	1-3	4-6
1. Sickness: 11.85**											
I have not been as healthy since the death of my spouse (i.e. asthma, rheumatism, colds, rashes, headaches, etc.).	S	7	4	8	3	2	11			19	16
	N		1	3	2	5	19	1		4	26
2. Finances: 1.71											
I have gotten along all right financially since the death of my spouse.	S	13	10	3	2	5	2			26	9
	N	17	9	1	1	1	2			27	4
3. Meaning of religion: 2.38											
I believe I have been more religious since the death of my spouse.	S	4	4	7	3	4	12	1		15	19
	N	2	4	2	7	3	13			8	23
4. Importance of the Church: 3.48											
My church has not been of very much help to me in the hard times since my husband/wife died.	S	11	4	7	2		9	2		22	11
	N	8	3	1	3	6	7	3		12	16

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
5. Quality of marriage at time of death: 6.63*											
Our marriage at the time of death was going "downhill."	S	7	4	5		3	16			16	19
	N	1	2	2	1		25			5	26
6. Funeral: 0.40											
I feel the funeral helped me greatly at the time of his/her death.	S	4	5	3	3	4	14	2		12	21
	N	2	4	6	2	3	10	4		12	15
7. Stigma of suicide: 6.69**											
At times I have felt like I was being compelled to move residence because of what some people thought about my spouse dying.	S	4		5			26			9	26
	N						29	2		0	29
8. Need of therapeutic intervention: 0.55											
I have felt like I (and/or my children) have needed counseling since the death of my spouse.	S	7	4	3	3	5	12	1		14	20
	N	3	4	3		2	19			10	21

Have you had counseling?
(Yes: S: 10 N: 3)
Had you ever had counseling before your spouse died?
(Yes: S: 12 N: 2)

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
9. Problems in raising children: 0.02											
My children have been more difficult to raise since my spouse's death. (Check if no children living with you at time of death.)	S	6	1	6	1		12		9	13	13
	N	4	4	4	1	2	8	1	7	12	11
10. Social withdrawal: 0.03											
Friends and relatives don't seem as close to me as they did before my spouse died.	S	6	1	5	2	2	18	1		12	22
	N	6	3	1		6	14	1		10	20
11. Religious solace: 0.02											
The death of my spouse has made me turn to God for help.	S	10	1	6	3	5	10			17	18
	N	4	3	7		1	15	1		14	16
12. Quality of marriage at time of death: 4.36*											
I don't completely understand why, but in the last few months before the death of my spouse, we argued and verbally fought a lot.	S	4	3	5	1	4	18			12	23
	N		2	1	2	2	24			3	28
13. Meaning in life: 0.05											
Since my spouse died I have not had anything to live for.	S	1		3		7	24			4	31
	N	1	2	1	2	1	23	1		4	26

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
14. Social involvement: 0.76											
I now feel left out of social life more than I used to be.	S	5	3	2	4	6	15			10	25
	N		6	6	2	2	15			12	19
15. Quality of marriage--intimacy: 0.04											
My spouse hardly ever confided in me.	S	2	2	1	6	5	19			5	30
	N	2	2	1		3	23			5	26
16. Perceived blaming of friends & relatives: 5.15*											
I have felt blamed by others to some extent for my spouse's death.	S	1		8		5	21			9	26
	N			1		1	29			1	30
17. Drinking: 1.49											
I am drinking more alcoholic beverages than before the death. (Check if never have drunk.)	S	2	4	6		1	16		6	12	17
	N	2		5	1	3	16		4	7	20
18. Anger at spouse: 6.92**											
There have been times since he/she died that I have felt mildly irritated or disappointed in him/her.	S	7	2	10	2	4	10			19	16
	N	1	2	4	1	1	22			7	24
19. Anger: 0.78											
Since my spouse died I get annoyed or irritated more easily than I used to.	S	3	1	11	2	10	8			15	20
	N	4	1	5	1	7	13			10	21

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
20. Loneliness: 1.95											
I am a more lonely person since the death of my spouse.	S	13	8	5	2	1	6			26	9
	N	8	6	4	3	1	9			18	13
21. Use of drugs: 0.38											
Since the death of my spouse I have been using more drugs (such as tranquilizers, sleeping pills, narcotics, pep pills, etc.).	S	1	1	3		2	27	1		5	29
	N	2	1				28			3	28
22. Feeling about future: 2.24											
I am not as confident about the future as I was before the death of my spouse.	S	7	6	7		2	13			20	15
	N	5		7	3	2	14			12	19
23. Crying: 3.55											
I have not cried to speak of since my spouse died.	S	3	2		5	6	19			5	30
	N	6	1	4	2	4	12	2		11	18

Resources

Circle any of the following which were very helpful in aiding you to adjust to your spouse's death.

	Suicide	Non-Suicide	Total
Yourself	24	19	43
Minister/rabbi/priest	6	8	14
Parental family	15	10	25
Other relatives	11	10	21
Your children	23	19	42
Counselor/psychotherapist	2		2
Friends	26	19	45
Prayer, reading the Bible	11	7	18
Church	8	4	12
Family doctor	6	5	11
Social worker	2		2
Other professionals	1	2	3
Funeral	4	2	6
No one	3		3
Other	4	6	10

Suicidal Behavior and Ideation

Circle any of the following which express your feelings since the death of your husband or wife. Mark "B" in front of the sentence which expresses your feelings before the death.

	Circled		"B"	
	S	N	S	N
Not thought about killing myself at all	19	22	14	15
Thought only a little about killing myself, but not for quite a while.	3	1	4	1
Thought about killing myself off and on.	4		1	

(Continued on next page.)

	Circled		"B"	
	S	N	S	N
Thought about killing myself fairly often but have not told anybody.	1	1		
Thought a lot about it and told others I felt like killing myself.		1		
Attempted suicide	1			
No answer	7	6	16	15

III. Please answer the following questions as to how you feel now.

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
24. Dependency vs. Independency: 0.65											
I feel independent now, not needing to depend on others.	S	8	10		2	7	8			18	17
	N	9	7	3	2	6	4			19	12
25. Importance of Religion: 0.23											
I can take religion or leave it.	S	9	4	3	4	8	7			16	19
	N	5	5	6	2	5	8			16	15
26. Prayer: 1.36											
Prayer can solve many problems.	S	11	1	8	3	4	8			20	15
	N	10	7	5			9			22	9

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
27. Lie: 3.71											
Once in a while I put off to tomorrow what I ought to do today.	S	10	11	12	1	1				33	2
	N	7	5	11	3	1	4			23	8
28. God's Providence: 0.48											
God protects from harm all those who really trust in him.	S	8	5	5	2	8	7			18	17
	N	10	4	4	2	2	8	1		18	12
29. Beliefs on suicide: 0.07											
Nothing is worth killing yourself for.	S	21	7	2	1	1	2	1		30	4
	N	27		1	1	1	1			28	3
30. Depression: 0.03											
It does not take me long to get over feeling gloomy.	S	10	9	5	4	2	5			24	11
	N	10	10	3	4	3	1			23	8
31. Perceived Social Respect: 0.77											
I am looked upon as being of small or no account in other people's eyes.	S			3	1	11	20			3	32
	N			1	1	3	25	1		1	29
32. Lie: 0.33											
Sometimes when I am not feeling well I am cross.	S	10	10	12	1	2				32	3
	N	11	3	13	1	2	1			27	4

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
33. Feeling of freedom (personal) & social constraint: 0.31											
I feel trapped, oppressed, forced to do things I don't want to do.	S	2	2	6	5	10	10			10	25
	N		4	3		4	20			7	24
34. Work: 1.13											
I get a great deal of satisfaction out of my work (Check if you have not worked full or part time since your spouse died).	S	14	9	2	2	3			5	25	5
	N	18	5	2			2		4	25	2
35. Anxiety or Calmness: 0.62											
I feel pretty generally secure and free from care.	S	4	10	6	4	5	6			20	15
	N	10	7	3	6	2	2	1		20	10
36. Belief on suicide: 0.31											
Suicide is morally wrong.	S	19	2	4	1	4	5			25	10
	N	22	1	1	2	1	4			24	7
37. Acceptance of the Loss: 0.04											
I still have trouble realizing that my spouse is dead.	S	10	5	5	1	3	11			20	15
	N	7	3	7	1	2	11			17	14

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
38. Impulsiveness vs. Self-Restraint: 0.01											
I refuse to allow myself the slightest self-indulgence or impulsive action.	S	3	2	5	6	9	10			10	25
	N	2	3	3	6	8	7	2		8	21
39. Sleep Disturbance: 0.01											
I have some trouble sleeping and wake up more tired in the morning than I used to.	S	4	2	8		8	13			14	21
	N	3	6	3	1		18			12	19
40. Fatigue: 3.41											
I feel physically tired much of the time.	S	4	8	6	2	2	13			18	17
	N	4	2	3	2	4	16			9	22
41. Punishment: 2.84											
At times I feel I deserve to be punished.	S			9		7	19			9	26
	N		1	2		6	22			3	28
42. Depression: 0.28											
I feel depressed and very low and miserable most of the time.	S		1	2	4	9	18	1		3	31
	N		2	2	1	5	21			4	27
43. Reaction to Consolation: 0.00											
After a while I got tired of people always trying to console me about my spouse's death.	S	4	3	6	4	2	14	2		13	20
	N	4	3	5	2	5	12			12	19

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
44. Guilt: 8.68**											
I feel guilty about some things I said and did before my spouse died.	S	4	5	15		5	6			24	11
	N	2	3	5	1	5	15			10	21
45. Openness with Feelings: 0.04											
I fear to express my deepest feelings to other people, even those close to me.	S	4	3	4	2	9	13			11	24
	N	2	4	3	4	3	15			9	22
46. Guilt: 5.54*											
I often think I should have done more for my spouse before he/she died.	S	7	7	8	1	6	5	1		22	12
	N	2	3	6	1	3	16			11	20
47. Guilt: 13.88**											
Although I feel I maybe shouldn't, at times I feel ashamed about the way my husband/wife died.	S	7	3	8	1	3	12	1		18	16
	N			3	1	2	25			3	28
48. Scape-Goating: 0.23											
If it weren't for my spouse, I'd be in a lot better shape today in this world.	S	1		1	5	4	23	1		2	32
	N			1	2	3	24	1		1	29

	S or N	1	2	3	4	5	6	N	✓	1-3	4-6
49. Stalemated grief reaction: 0.29											
I just can't seem to get over the death of my spouse.	S	7	4	6		6	12			17	18
	N	2	4	7	1	3	14			13	18
50. Guilt: 6.20*											
Although I don't like to think of it, I feel at times as if I were part of the cause of my spouse's death.	S	1	4	10	2	3	14	1		15	19
	N			4	1	2	24			4	27
51. Self-confidence or feeling of inadequacy: 0.03											
I am distressed by my weakness and lack of ability, sick of my incompetence.	S	2		2	1	3	27			4	31
	N	1	1	2		4	23			4	27
52. Lie: 0.03											
I do not like everyone I know.	S	6	5	10	2	4	8			21	14
	N	8	2	8	2	4	7			18	13
53. Avoidance of lost object: 0.11											
I try to avoid anything that reminds me of my spouse.	S	1	1	1	2	7	23			3	32
	N		2		1	6	22			2	29

* $p < .05$.
** $p < .01$.

APPENDIX I

PHASES OF THE GRIEF REACTION

SEVEN PHASES OF GRIEF:

1. Stunned and Shocked.

When death comes to a family often the pain of the separation is so intense that the mind numbs the pain as it does in any shock reaction, until later, when the body can better accept it. The person is in a sense temporarily anesthetized against the overwhelming expe-rience he is facing.

2. Catharsis.

Usually the first phase of the grief reaction doesn't last very long (though it may return from time to time for short periods), and the release of emotion (catharsis) begins. The stark reality of the loss begins to really grip the bereaved. Here the minister and friends can encourage him to express what he actually feels--to really let go, rather than bottling it up. Often when one emotion is released, others are forthcoming. In this stage the feelings of which I speak in later phases (especially three through five) often begin to emerge. Sometimes these feelings will scare both the bereaved and

the people around him. It is the task of the minister to help them realize that venting emotions is normal and natural.

3. Depression and Guilt.

The third phase of the grief reaction is the feeling of depression and guilt. These are two closely intertwined phenomena. Guilt is the almost inevitable occurance after the death of a loved one. Unfortunately this feeling is not always recognized as such by one who is experiencing it. It is seldom spoken of freely because it is more popular and accepted to speak only of "grief." Oftentimes a person feels very lonely and unacceptable during the grief reaction and will go into periods of despair and depression. These periods of depression are, as I see it, often incubation periods for the later expressions of guilt feelings and also feelings of anger concerning the deceased. Because of the unusual aspects of the grief reaction with exaggerated guilty feelings, the long periods of depression and anger at the dead person, the bereaved may fear he is going insane or having a "nervous breakdown." Friends, including the minister, need to stick close to the grieving person in this stage and not be frightened away or feel rejected by his irritability or any disturbing ideation.

4. Preoccupation With the Loss.

Lindemann points out that there is often an intense preoccupation with the image of the deceased. He cites the case of an armed forces pilot who reacted to the death of a close friend by constantly fantasizing him. He was an imaginary companion who ate, drank and did everything with him. This is a morbid grief reaction and calls for therapeutic help. Often with the focus of most of his attention on the loss, the grieving person has a difficult time concentrating on anything; he doesn't do well at work, the house is always a mess, school work is neglected, etc. Again in this phase there is frequently fear of going insane.

5. Feelings of Hostility and Expression of Anger.

This stage is always, I feel, a good sign because it usually means the person is beginning to come out of his depression and his constant focusing on the dead person, and is expressing himself again. He bitches about those who have been around him in the final stages of death and during his previous stages of grief (which includes doctors, nurses, ministers). The clergyman who has a picture of himself as a "nice guy" and has trouble with conflict or hostility needs to be ready for this so he won't feel totally rejected or think that all his "help" is down the drain. He needs to let the grieving person know that hostility and expression of anger is normal

and acceptable. Often during this stage (as well as others) there can be a myriad of somatic problems. The bereaved has to be aware that grief is an emotion, and like all emotions it involves physical changes --churning or disruption of the stomach, ulcers, headache, etc. Strong emotion creates fairly drastic physical effects and the minister needs to be aware of these--to help the person see a doctor or seek counseling if needed.

6. Unwilling or Unable to Readopt Normal Activities.

At this stage the bereaved may try to get back in the "groove," like it was before the loss, but he is unable to. To quote Lindemann,

> There is a restlessness, inability to sit still, moving about in an aimless fashion, continually searching for something to do. There is, however, at the same time, a painful lack of capacity to initiate and maintain organized patterns of activity. . . . The bereaved is surprised to find how large a part of his customary activity was done in some meaningful relation to the deceased and has now lost its significance. [1]

What is sad is that here the person still feels the loss and yet when he begins to move back into life again, no one talks about his loss much beyond a few weeks after the funeral. Yet he still feels it, and moving back into regular life is somewhat like an alien environment to him. As Westberg puts it, there is a kind of "conspiracy of silence" concerning the death.

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[1]Erich Lindemann, "Symptomatology and Management of Acute Grief," Pastoral Psychology, XIV:36 (September, 1963), 10.

7. Adjusting to Reality.

This final stage of the grief process stems from an awareness of the futility of continued withdrawal from reality. The person is really a changed or new person, because he has gone through the loss of a loved one and now lives on, facing life hopefully a stronger, deeper person, better able to help others go through the same experience.

These are the seven phases of the grief reaction as I understand it. The normal grief process can take up to three or even five years to work through. A person cannot be expected to go through all these stages. Yet, almost always, all of these phases appear to some extent.

APPENDIX J

CHI SQUARE TESTS NOTED IN CHAPTER SIX

Organizational Attendance and Counseling Before the Death.

		Organizational Attendance	
		Regular	Non-Regular
Counseling before the death:	Yes	5	9
	No	16	33

X^2 = 0 (corrected for continuity).

Education and Counseling Before the Death.

		Education	
		College	No College
Counseling before the death:	Yes	9	5
	No	25	24

X^2 = .33 (corrected for continuity).

Religion and Education.

	Education	
	College	No College
Protestant	19	19
Roman Catholic	7	6

X^2 = 0 (corrected for continuity).

Religion and Present Income.

	Present Income	
	$0-8999	$9000+
Protestant	22	15
Roman Catholic	4	8

X^2 = 1.57 (corrected for continuity).

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